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NORTHWEST TERRITORIES AIDS PROJECT - REVIEW

AIDS - PREVENTION IN THE NORTH

DEMONSTRATION and EVALUATION of CULTURALLY ADAPTED, COMMUNITY ORIENTED PREVENTION

Northwest
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A REVIEW OF THE NORTHWEST TERRITORIES AIDS PROJECT

AIDS - PREVENTION IN THE NORTH DEMONSTRATION AND EVALUATION OF CULTURALLY ADAPTED, COMMUNITY ORIENTED PREVENTION

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1992

The Department of Health of the Government of the Northwest Territories extends its appreciation to Health and Welfare Canada, National Health Research and Development Program and the Federal Centre for AIDS for their financial support of this project.

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EXECUTIVE SUMMARY

Introduction

In the early 1980's, the first case of HIV infection was diagnosed in Canada. Concurrently, the World Health Organization alerted public health officials and governments around the world that this new sexually transmitted infection and the resulting disease, AIDS, was rapidly spreading around the globe. There is no known cure for this infection. The result is that this infection has a devastating effect on the social, economic and health conditions of a country. Therefore, it is important that the public be made aware about the infection, and how to prevent its spread. Also, health services and communities around the world need to prepare for the care of people with the resulting disease known as AIDS.

The Northwest Territories has a population of 55,000 people located in 62 communities, of which the majority range in size from 250 to 3,000 people. Yellowknife, the capital of the Territories, has a population of 16,000 people. Geographically, the population is spread over a vast area of land. More than 50% of the people are of three distinct aboriginal cultures: Inuit, Dene and Metis. The Government of the Northwest Territories is the only jurisdiction in Canada that has an Official Languages Act which includes aboriginal languages. Although many of the aboriginal youth speak English, other members of their family, particularly the elders, are unilingual in their own language. The diversity in language and culture, and the geographic spread of people both had to be incorporated into the planning of health education programs, and in particular when trying to tell people about this new disease and how to prevent its spread.

Purpose and Funding of the Project

In 1987, the Government of the Northwest Territories' Health Promotion Program obtained funding for an AIDS project from the National Health Research and Development Program, Health and Welfare Canada. This project was called **"AIDS Prevention in the North - Demonstration and Evaluation of Culturally Adapted, Community-Oriented Prevention"**. The aim of this project would be to initiate professional and public awareness and prevention about AIDS.

Initially, the project was to operate for only three (3) years. Health and Welfare Canada's National Health Research and Development Program provided $750,000.00, and the Government of the Northwest Territories provided the salary for one position ($55,000) and some in-kind services. Later, a fourth year was added with funds being supplied by both the GNWT Department of Health, and Health and Welfare Canada's Federal Centre for AIDS. Because the project was coming to a close, not all funds supplied by the Federal Centre for AIDS were used, as staff left for other jobs.

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Organization of the Project

Six months after the project began (in April of 1988), the Federal Government transferred the administration of all its health services in the Northwest Territories to the Government of the Northwest Territories. These changes directly contributed to the uncertainty in the structure and staffing of the project. However, the dedication of the project staff, and in the early years, its Advisory Committee, ensured its achievements.

Evaluation of the Project

The evaluation was undertaken in two phases. Phase 1 included the history of the project and its objectives, and quantitative results about the various tasks and activities undertaken during the time of the project. A new member of the Department of Health staff with no previous association with the AIDS project recorded this information from Department of Health files. In Phase 2, the GNWT Department of Health hired Kate Tompkins and Associates, a local contractor, to collect opinions of former project staff, caregivers, educators and the public about various activities and tasks of the project.

Unfortunately, methods for evaluating the project were not firmly established at the beginning of the project, because of the changing organizational structure of health services in the Territories, and the frequent changes in staff. Thus, the evaluation had to be conducted post facto or retrospectively. Most of the opinions were obtained many months and in some cases years after the fact. Research shows that asking people to recall events more than 3-6 months after they occurred increases the probability of inaccuracies. Thus, the amount of some services provided by the project staff are underestimated. Nevertheless, public and professional opinions collected in the survey have provided an indication of perceptions about services which can be useful for the further development of programs.

Findings of the Project

During the project over 153 workshops or presentations were provided to communities and health and social services professionals. Roughly 3,500 people attended these presentations. The professional nursing staff had a high turn-over during the life of the project, largely due to the changes in the organization of health services in the Territories. Thus, some of the regions were visited more frequently than others. To supplement the education of the professional staff, special advice was available from the Infectious Disease Control Unit and through a manual developed by the Medical Directorate. However, the need to continue the education of professional staff is ongoing.

In the last two years of the project, Popular Education techniques were used with local community groups. These techniques helped community groups to begin to take responsibility for themselves about the prevention of AIDS. This planted the seed for community action which began to grow after the life of the project.

Because of the large distances between the people of the north, the radio and TV were the most efficient ways to reach people in all languages and cultures. Thus the production of materials for these forms of mass communication became essential.

Ten public service announcements for TV were developed and aired by CBC North in all the official languages of the Northwest Territories. The English versions of a few of these also were used by at least three other provinces. A radio drama was produced by the Native Theatre Group. Copies of this drama have been sent to all the schools in the Territories and are still used today. Other radio spot announcements were also produced. Project staff also used the local radio talk shows as another means of reaching the public.

An AIDS telephone hotline was established with a "800 number", so that residents could call for information or ask questions about HIV infections and AIDS. This line was only answered in English and some community groups would have liked to have it available in a number of different languages and dialects. The line was answered by the project's professional staff.

Print materials and promotional items were also produced in various forms: posters, pamphlets, coasters for use in bars and at parties, free condoms in the health centres and Department of Health offices, and paid advertisements in newspapers (810 ads) and popular inflight magazines on planes. It should be noted that the latter means was chosen because the only means of transportation between most communities is by air, and thus a broad segment of the population is reached. These ads appeared in all of the official languages of the NWT.

The Department of Health project staff also worked with the Department of Education in preparing a segment of the School Health Curriculum about sexually transmitted diseases including HIV infection. The Department of Health and the Department of Education worked collaboratively on many activities related to youth and AIDS. Special workshops were held with managers on AIDS policies in the workplace; with inmates in correctional institutions; with members of the clergy; and with alcohol and drug workers. Advice was provided to special national initiatives on HIV infection.

Conclusions

The project, officially called **"AIDS Prevention in the North - Demonstration and Evaluation of Culturally Adapted, Community-Oriented Prevention"**, did initiate professional and public awareness and prevention about AIDS. This was achieved through a number of mass media forms of education which reached a broad segment of the population. The education was done in all of the aboriginal languages of the Territories so that people of all ages and cultures could learn about what this new disease was and how to prevent its spread.

A centrally organized means of delivering the education programs could not be maintained over the long term, because of economy of scale, the need for communities to take ownership in delivering the service, and because of the increased need for local aboriginal health workers to do health education.

Today, the GNWT operates a decentralized health care system. Responsibility for AIDS programming occurs at two levels: in the regions and in the Territories. At the regional level, the Regional Hospital/Health Boards and Health Services are responsible for the delivery of AIDS programming in their jurisdictions. This includes public education, counselling of individuals and families about the disease, and care and treatment of those with HIV infection/AIDS.

Territorially, the Department of Health's responsibility is to act as a resource to the regions in the development and evaluation of their programs by funding staff and special program initiatives, assisting Regional Health Boards with the training of health workers, and advising on and consulting with the regions about setting standards and procedures related to HIV infection and AIDS. In addition, it works with non-government agencies and community groups and professional groups who are also taking action in the prevention of HIV infections.

In the one-and-a-half years since the end of the project, there has been a steady increase in local people, groups, communities, health units and non-government organizations initiating services to meet the needs of people in their communities. The AIDS project laid the foundation for these activities.

Recommendations

The local contractor also provided recommendations about future directions for AIDS programming in the Territories as part of her report. These have been included for consideration.

The following are the major recommendations made by the contractor after reviewing the AIDS Project:

RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

This section lists specific recommendations aimed at the Department of Health for the future AIDS behaviour-change campaign [1].

Regarding Policy

1. Promote discussion in the Legislative Assembly which will bring AIDS and the need for a new campaign to the forefront.

2. Lobby with senior representatives of each Department of the Northwest Territories to establish procedures to promote co-operation between departments at a local level to prevent AIDS and provide care for AIDS patients and their families.

3. Develop a policy immediately which clearly states the desire of the Government of the Northwest Territories to involve all community resources in the AIDS Project. The policy must indicate government support for non-governmental agencies and individuals who wish to initiate an AIDS Project. The primary resources at a community level will be churches, drug and alcohol workers, social workers, and adult educators.

4. Develop a government-wide policy for presentation to the Executive and the Legislature to ensure all government departments are actively involved in the program to combat AIDS.

5. Continue to provide leadership to the government and its agencies in the development of in-house policies that detail the position the government or its agencies will take when an employee or client is infected.

6. Design an overall suggested policy or set of policies which can be used to assist private employers in developing their own strategies to deal with an infected employee.

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[1] These recommendations were formulated in 1991 by an independent consultant, and are currently being considered together with other Department of Health policies and initiatives.

Regarding Relationship to Regional Health Boards and Community Groups

7. Organize, host and chair a conference with representatives of the following:

   - each Regional Health Board
   - each government department's senior leadership and regional offices
   - major native organizations
   - other important interest groups such as Status of Women, Pauktuutit, Native Women's Association, and friendship centres
   - leadership of the Arctic Dioceses of the Anglican Church and the Roman Catholic Church
   - Canada Employment and Immigration
   - Arctic College
   - community caregivers
   - traditional Dene and Inuit healers
   - CHR's

   The main goals of the conference would be as follows:

   - reactivate the image of AIDS as a current risk to the people of the Northwest Territories
   - update recent developments regarding AIDS and the local epidemic
   - establish guidelines for policy development
   - establish priorities for program and materials development
   - develop a structure that will allow blurred boundaries, shared responsibilities, and joint action against all of the lifestyle issues which affect AIDS
   - share the results of those portions of this study which relate to the public
   - prepare NWT-wide strategies for action

8. From the delegates to this conference, select a task force which will advise on and oversee the further development and implementation of the strategies arising from the conference.

9. Develop a system to inform health care professionals in the regions of the existence of known cases of HIV in their region.

10. Secure the funding required to provide each Regional Health Board with a person year for a Health Promotion Officer whose main responsibility will be AIDS education.

11. Provide explicit training to regional health care staff about how to discharge the tasks delegated to regional responsibility.

12. Develop practical guidelines for AIDS Project development and implementation which can used by the Regional Health Boards to prepare their programs. Packages should include:

    - development models for designing policies for employers and agencies
    - suggested job descriptions for those involved with AIDS education
    - models for the content and format of any educational materials which are to be developed locally.
    - a copy of recommended videos and other resources
    - lists of resources which can be ordered, along with addresses and costs of each
    - a recommended model for small group learning, similar to that used by the Family Life Educators, "Working Together For Change"
    - recommended models for treatment and follow-up care for HIV infected persons and their families
    - recommended techniques and models for bringing community agencies, government departments and other local resources together in a joint working group to prevent the spread of AIDS and prepare for future counselling and treatment requirements
    - recommended sources of funding available to local organizations and copies of sample completed application forms as guides for fund raising

13. Develop a list of protocols to guide the recruitment and support of northerners diagnosed as HIV+ to act as speakers. Take a proactive role in arranging for and funding speaking tours.

14. Expand the role of the Family Life Educators with a focus on the "Working Together For Change" program. The goal should be to facilitate the delivery of ongoing workshops regularly in each region as a focal point for personal change and community development.

15. Maintain a regular AIDS information training schedule for local caregivers, including nurses and CHR's. The focus should be on counselling, treatment and care of patients and families, testing, and the impact of the AIDS virus on victims. There should be at least two training workshops for professional caregivers in each region each year.

16. Continue to provide leadership and continuity in the development of all learning materials, in particular video. Ensure that educational materials, whether developed by the Yellowknife AIDS Project or by regional resource persons, share the same focus to ensure accuracy and consistency of message.

Regarding The Structure of the AIDS Project

17. Assign to the AIDS Project exceptional powers and independence [2]. This may require its establishment as an arm's length body or use of some administrative technique to remove it from the usual chain of authority and decision-making accountability which impeded its operations in the past. Use the highest professional standards in the selection of staff.

18. Secure the required funding to establish a media centre in Yellowknife whose main task will be to produce appropriate learning materials which can then be used by local caregivers for their AIDS education activities. Focus will be on audio/video materials.

19. Locate the funding to establish regional HOTLINES. Provide training to local counsellors using a professionally developed counsellor training program. Move the present line to the Medical Directorate and make it a line dedicated to dealing with the specific queries of medical professionals.

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[2] Editor's note: This Project has been phased out.

Regarding AIDS Project Activities

20. Plan for evaluation while planning program delivery. Develop an evaluation strategy which includes:

    - measurable, attainable, challenging performance standards
    - strategies for collecting useful information on a regular basis
    - format for recording information consistently
    - structure for reporting information regularly
    - formal evaluation conducted annually by an outside agency

21. Consult with other departments of the Government of the Northwest Territories to learn what information their field workers can contribute to the development of AIDS programs and materials.

22. Assist other departments of the Government of the Northwest Territories to develop programs aimed at the long-term healing of social structure as a way to prevent the spread of AIDS.

23. Develop an animated video, cartoon style, of no more than 30 seconds in length which uses "Proud Pete" as its inspiration. The accent should be on humour, graphics with no verbal or written overlay, and brevity.

    Produce multiple copies of the video for use as a "trailer" along with commercial videos shown at community theatres, on TV and similar uses.

    Have copies of this and other appropriate videos available for free use from existing video outlets. Provide a copy in the packages made available to Regional Health Boards.

24. Produce a video using elders to discuss lifestyle issues, such as spirituality, values, choices, and personal and community growth. Present lifestyles of native persons who have a positive image as role models.

    Provide a copy in the packages made available to Regional Health Boards.

25. Update radio and TV ads regularly to maintain attention.

26. Assist the Department of Culture and Communications in negotiating with the most-watched TV stations received in the NWT to insert short AIDS clips into commercial programming.

27. Develop and produce new media messages:

    - produce new radio dramas in English and Inuktitut.
    - develop a new round of TV ads and dramas and other programming.
    - lobby for an NTV special on AIDS in the Northwest Territories.
    - develop new posters which are linked directly to the radio and TV ads.

28. Repeat newspaper, TV and radio ads which have not been aired for some time as an immediate strategy while new materials are being developed.

29. Assist the Departments of Social Services and Education in developing resources for their community workers to help people cope with and give up substance abuse.

30. Provide free condoms to more outlets, including businesses such as video rental counters, convenience stores, fast food restaurants, schools, adult education centres, counselling centres, friendship centres and any other organization which requests them. Encourage the display of condoms in easily accessible locations.

31. Conduct a comprehensive sexual practices survey, perhaps using the recent survey completed in Great Britain as a model. One of the goals of the study should be an examination of the cultural mores surrounding sexual practices in the Northwest Territories.

32. Lay plans now for facilities which can serve as primary treatment facilities and hospices for AIDS patients. Existing programs such as homecare should be expanded.

RECOMMENDATIONS FOR REGIONAL HEALTH BOARDS

This section contains recommendations for regional health care staff who are charged with the responsibility of AIDS programming.

1. Plan for at least one person year for a position responsible for the co-ordination of AIDS-related activity in the region. Develop a well-articulated job description with activity directed at community change.
2. Locate an appropriate and dedicated budget to fund AIDS programming.
3. Provide co-ordination to local and regional groups who wish to initiate AIDS programming. Assist with locating suitable resources or developing affordable alternatives with specific local context.
4. Lobby the headquarters of the Department of Health to provide program guidelines, assistance and training for AIDS work.

CHAPTER 1

INTRODUCTION

In the early 1980's, the first case of HIV infection was diagnosed in Canada. Concurrently, the World Health Organization had alerted public health officials and governments around the world that the new HIV infection and the resulting disease, AIDS, was rapidly spreading around the globe. There was (and still is) no known cure for this infection. The World Health Organization warned that this infection could have a devastating effect on the social, economic and health conditions of a country. Therefore, it was important that the public be made aware about the HIV infection, and how to prevent its spread. Also, health services and communities around the world would have to begin to prepare for the care of people with the resulting disease known as AIDS.

In the Northwest Territories, health programs related to AIDS began with the Federal Government in 1985. In that year, a document about AIDS testing produced by the British Columbia Ministry of Health was distributed to all health care workers in the Territories. Dr. Alistair Clayton, then Director of Disease Control for Health and Welfare Canada, travelled to the Northwest Territories. He spoke with both Federal and Territorial Government and hospital officials, as well as nursing, medical, corrections and legal people about AIDS, the need to prevent the spread of this infection, and its impact on peoples' lives and services. In addition, he spoke with the Gay and Lesbian Association, Family Counselling staff, Drug and Alcohol Workers and the general public. From these catalysts, an AIDS Advisory Committee was established by the Government of the Northwest Territories. The Committee's first task was to develop and distribute to professionals a package of information about the screening of emergency blood donors.

Characteristics of the Residents of the NWT

Distributing information about AIDS and providing AIDS programs to NWT residents will present special challenges for NWT health professionals, as the characteristics of the NWT population differ dramatically from Canada as a whole. The NWT is the only territory or province where Native people make up the majority of the population, and the age distribution **(See Appendix D)**, birth and fertility rates and death rates by age are quite different from general Canadian statistics. Any assessment or treatment programs designed for the NWT, in particular AIDS education and treatment programs, must take into account the unique composition and distribution of its population.

In addition, the Official Languages Act dictates that information and services may soon need to be available in each of the several official languages of the NWT. This diversity of language and culture, coupled with the vast distances between communities, makes provision of educational services and materials, and treatment programs challenging.

Development of the AIDS Project

In 1987, the Government of the Northwest Territories (GNWT) Health Promotion Program obtained funding for an AIDS Project from the National Health Research and Development Program (NHRDP) of Health and Welfare Canada. This project was called **"AIDS Prevention in the North - Demonstration and Evaluation of Culturally Adapted, Community-Oriented Prevention"**.

The aim of this project was to initiate professional and public awareness and prevention about AIDS. Initially, the project was to operate for only three (3) years, at a cost of $750,000. Later, a fourth year was added with funds being supplied by both the GNWT Department of Health, and Health and Welfare Canada's NHRDP Program. The GNWT funded the operation of the project, and Health and Welfare Canada paid for the salaries.

Six months after the project began in April, 1988, the Federal Government transferred the administration of all its health services in the Northwest Territories to the Government of the Northwest Territories. The AIDS Project and its funds were then regarded as "seed money" for the eventual development of an AIDS Program to be fully operated and funded by the Government of the Northwest Territories.

Organization of Government Services

Today, the GNWT operates a decentralized health care system. Regional Health and Hospital Boards and Services are responsible for the delivery of health services within their jurisdiction. The Department of Health has responsibility for funding of regional services, Territorial-wide program development, monitoring and evaluating programs, and setting program standards and policies. This is done in consultation with the regional Services, Boards and staff. Thus, government responsibility for AIDS programming exists at two levels; at the Department of Health and with regional hospital/health boards.

Territorially, the Department of Health's responsibility is to act as a resource to the regions in the development and evaluation of their programs, as well as to fund staff and special program initiatives, assist Regional Health Boards with the training of health workers, and advise on and consult with the Regions about setting standards and policies related to HIV infection and AIDS. In addition, local community and professional groups are also taking action on the prevention of HIV infections.

At the regional level, the Regional Hospital and Health Boards and Services are responsible for the delivery of AIDS programming in their jurisdictions. This includes public education, counselling of individuals and families about the disease, and care and treatment of those with HIV infection/AIDS.

Funding of AIDS initiatives at the regional level comes from the GNWT Department of Health, and Health and Welfare Canada. In 1990, Health and Welfare Canada issued a National HIV Strategy. Part of that strategy has been to offer funding to community groups to undertake services related to HIV infections. This program is known as the AIDS Community Action Program (ACAP). To date, three community groups in the Territories have benefitted from this program.

Evaluation of the Project

As the major funder for the AIDS Project, the National Health Research and Development Program, Health and Welfare Canada required that an evaluation of the AIDS Project be conducted. The results of this evaluation will be of interest to others in developing programs, and to the Department of Health, Regional Hospitals, Health Boards and Services and local groups in planning and operating future programs.

Unfortunately, methods of evaluating the project were not firmly established at the beginning of the project, because of the changing organizational structure of health services in the Territories, and the frequent changes in staff. Later, methods of collecting data about the project services were established. Thus, the amount of some services provided by the project staff are underestimated.

The effectiveness of some of these services, in particular some educational materials, were largely based on recall of events, as well as opinions of the public, educators and professionals. By and large, the evaluation has been conducted post facto or after the fact. Most of the opinions were obtained many months, and in some cases, years after the fact.

Research shows that asking people to recall events after more than 3-6 months increases the probability of inaccuracies. Nevertheless, public and professional opinions collected in the survey have provided an indication of perceptions about services which may be useful for the further development of programs.

The methods used to collect the information are detailed in **Appendices B and C**.

It is important to note that other HIV/AIDS programs were operational at the same time as the AIDS Project, thus introducing significant confounders to any measure of Project impact or effect. In particular, many activities of the Medical Directorate's Infectious Disease Control Unit undoubtedly influenced popular perception and response to the developing epidemic, as did cable television, radio, and other forms of media. This would render assessment of the Project per se more difficult.

Organization of this Report

The results of the evaluation are reported in Chapters 2 to 5 inclusive. The history of the project and its objectives are described in Chapter 2. Quantitative results about the various tasks and activities undertaken during the time of the project are reported in Chapter 3. Department of Health staff and the evaluation consultant collected this information from Department of Health files.

Chapters 4 through 7 of this report detail the expressed opinions of the independent contractor (Kate Tompkins and Associates) who was hired by the Department of Health to conduct this aspect of the evaluation of the AIDS Project.

Chapters 4 and 5 are opinions of former project staff, caregivers, educators and the public about various activities and tasks of the project. Conclusions about the project are discussed in Chapter 6. The local contractor also provided recommendations about future directions for AIDS programming in the Territories as part of her report. These have been included in Chapter 7 for discussion and consideration.

CHAPTER 2

IMPACT OF THE CHANGING ORGANIZATIONAL ENVIRONMENT ON THE PROJECT

The transfer of the administration of health services from the Federal to the Territorial Government soon after the project began had a major impact on the objectives, structure and organization of the project. This impact in turn affected staffing, the delivery and completion of some planned project activities and tasks.

As the organizational structure evolved, so did objectives of the AIDS project and the strategies used to achieve those objectives. A summary comparison of project goals to activities completed can be found in **Appendix A**.

AIDS PROJECT OBJECTIVES

Below are the six original project objectives:

1. The Project would produce and distribute English and Native language HIV/AIDS educational materials (print, audio, visual.)

2. The Project would provide information, counselling and referral services to persons affected by HIV/AIDS.

3. The Project would provide training for a variety of groups, including health, social service and educational professionals and managers.

4. The Project would promote community responsibility toward HIV prevention and management by provision of local and regional workshops.

5. The Project would support unique community HIV/AIDS education projects.

6. The Project would consult on public, private and government HIV/AIDS policies.

The 1988/89 fiscal year was a continuation of the work begun in mid-1987 with three major strategies added. These three new strategies were:

1) Fostering Public Participation

2) Strengthening Community Health Services

3) Policy Development

1. Fostering Public Participation

This goal was supported by activities that included mass circulation using all media sources available to the north. Specifically, the activities included:

- advertisements in territorial newspapers;
- community public service television ads;
- radio advertisements;
- production and distribution of posters and pamphlets;
- the use of appropriate press releases;
- production of a bi-monthly "AIDS Update" newsletter, and
- the production of commercially produced videos.

In addition, information was to be collected and stored in facilities for easy retrieval by the public or interested persons. This was to be accomplished by:

- the establishment of a resources centre. Selected items were to be made available on a loan basis through the Otto Schaefer Health Library and Resource Centre, and
- the development and maintenance of a toll-free AIDS hotline.

A series of educational activities was to be developed. These activities included the provision of speakers from the AIDS Project to groups or organizations for general information on AIDS. The AIDS Project staff would also provide speakers for in-service training for professional workers in the communities.

Within this educational mandate the AIDS staff would assist communities in planning and facilitating workshops. In this task it was expected the staff would train community AIDS representatives (lay people) to increase community-based information and dialogue.

In recognition of uniquely northern needs, and to deal with the AIDS education task, funds were to be contributed to small community-based programs to develop models for other programs to follow. In this same vein, the Native Theatre Group was to be assisted in presenting interactive theatre on AIDS issues in several communities, a project which was eventually funded by the AIDS Community Action Program (ACAP).

2. Strengthening Community Health Services

This strategy was designed to address the remoteness of the majority of NWT communities from, and lack of easy contact with, major centres. To provide this service the Project sent out a newsletter, "AIDS Update", to health professionals with the latest information. The Project was to provide professional in-service training to health care professionals and para-professionals. The Project would also maintain a liaison with other agencies concerned with the care and well-being of the people of the north. Community workers from other agencies (both government and non-government) who were intimately involved with people and life behaviour issues were to be trained to increase the co-ordination of services and support in the communities.

3. Policy Development

The final 1988/89 task was to co-ordinate public policy on AIDS. This task included assistance to adopt a Personnel Policy on AIDS for the Government of the Northwest Territories. Also, this service would be available to Government Departments and private sector employers who needed assistance in developing their own policies and directives.

In this time period, the AIDS Project set three goals:

1. Reduce the inequities in services and access with regards to AIDS education.
2. Increase AIDS prevention at regional, community and personal levels.
3. Enhance the ability of individuals to cope with the threat of, and prepare for the reality of, AIDS infection in the north.

The goals and activities for the 1989/90 year were identical to those developed for the previous year.

The 1990/91 funding proposal refined and added to the project objectives:

1. a) Develop and provide an education program for GNWT personnel about AIDS policy and prevention of HIV.

   b) Prepare an "HIV in the Workplace" education program for both public and private sectors.

2. a) Conduct seven regional workshops to train "educators" (e.g. nurses, teachers, CHR's) about prevention of HIV infections and dealing with community attitudes.

   b) Conduct a demonstration project using a teleconference to update health professional staff about HIV infections and policies and procedures related to this disease.

3. Develop an HIV prevention video in conjunction with local cultural theatre groups for use in community education.

4. Consult with the Long Term Care Program about its policy and procedures regarding the care of a patient with HIV, and education needs of home care staff.

5. Explore the feasibility of expanding current education services to correctional centres in the Territories, and review with Corrections Service their current policy and guidelines about AIDS.

6. Assess the prevalence of injection drug use in the Northwest Territories in consultation with the Medical Directorate, Social Services and law enforcement officers, and design and implement an appropriate HIV strategy.

7. Revise the current television public service announcements.

8. Evaluate the effectiveness of the N.W.T. AIDS Project education and preventive strategies.

The objectives for the 1990/1991 year carry on the same themes as for previous years, with focus on different and more detailed strategies:

1. a) Develop and provide an education program for GNWT personnel about the AIDS policy and the prevention of HIV.

   b) Prepare an "HIV in the Workplace" education program for both public and private sectors.

2. a) Conduct 7 regional workshops to train the "educators" (e.g. nurses, teachers, CHR's) about the prevention of HIV infections and dealing with community attitudes.

   b) Conduct a demonstration project using a teleconference to update health professional staff about HIV infections and policies and procedures related to this disease.

3. Develop an HIV prevention video in conjunction with local cultural theatre groups for use in community education.

4. Consult with the Long Term Care Program about its policy and procedures regarding care of a patient with HIV, and education needs of Home Care staff.

5. Explore the feasibility of expanding current education services to correctional centres in the Territories, and review with Correction Services their current policy and guidelines about AIDS.

6. Assess the prevalence of injection drug use in the Northwest Territories in consultation with the Medical Directorate, Social Services and law enforcement officers, and design and implement an appropriate HIV intervention strategy.

7. Revise the current television public service announcements.

8. Evaluate the effectiveness of the NWT AIDS Project education and prevention strategies.

STRUCTURE AND ORGANIZATION OF THE PROJECT

Prior to the transfer of all health services from the Federal to the Territorial Government, the Medical Services Branch of Health and Welfare Canada was responsible for the medical administration of AIDS in the Territories, including the epidemiology and infectious disease control and the training of professional staff. At the same time, public education about the prevention of illness was the responsibility of the Government of the Northwest Territories Health Promotion Program. Thus, the AIDS Project was established as one part of the overall GNWT Health Promotion Program.

After the transfer of health services to the GNWT in 1988, the AIDS Project remained a part of the Health Promotion section, while the epidemiology and infectious disease control and training of professional staff became the responsibility of the new GNWT Medical Directorate. The AIDS Project and its reporting structure after the transfer of health services is illustrated in **Appendix E**.

MANAGEMENT AND STAFFING OF THE PROJECT

Staffing

The AIDS Project was managed by a Project Co-ordinator. Initially, the AIDS Project Co-ordinator reported directly to the Head of Health Promotion. There was a long period of confusion with several different AIDS Project Co-ordinators or acting co-ordinators, leading to unclear job duties and reporting relationships for some of the staff.

Reporting relationships within the AIDS Project and the Health Promotion section also changed. Later the AIDS Co-ordinator reported, at least in practice, to the Director of Community Health. Originally, the Project was to have 3 professional staff in addition to the Project Manager and a secretary, but not all of the AIDS staff positions were always filled. An overall summary of the job titles and duties originally conceived for the AIDS Project staff follows:

Project Clerk:	- daily office functions
Public Affairs Officer:	- developing and producing educational materials and programs, fielding inquiries from media
Project Co-ordinator:	- staff supervision, setting policies and guidelines, co-ordination of all AIDS Project functions.
Nurse/Educator:	- testing clients for HIV, counselling, educating health care professionals
Counsellor/Educator:	- answering HOTLINE, providing counselling services, providing training to community caregivers
Researcher:	- developing system to monitor STD's, research into AIDS information, establish and maintain AIDS information files for AIDS staff and health care professionals

Throughout the life of the Project three main types of positions were filled: the Project Co-ordinator, the Public Affairs Officer and the Researcher. A Secretary was also available to the Project.

Initially, a Nurse/Educator was hired and worked for 1.0 years. However, the need for a Counsellor/Educator for HIV patients or those at risk was not dominant. There was a greater need for a Nurse/Educator. However, changing this position resulted in reclassification problems with the Department of Personnel. Once this was resolved, a suitable candidate for the position could not be found. Concurrently, to provide the needed services some tasks of the Counsellor/Educator were merged with those of the Nurse/Educator position.

After two years, the Researcher position was transferred to the Medical Directorate. **(See page 12, "Linkage with the Medical Directorate".)**

The most recent movement is for regional health boards to take more responsibility for health education, in consultation with the Health Promotion Officers in Yellowknife. From the time of transfer, the Regional Health Boards have been taking on more and more responsibility for delivery of services, but project funding has kept administration and delivery of service in Yellowknife for the most part. As of April 1, 1991, Regional Health Boards have all responsibility for direct delivery of health care, and Yellowknife will retain the responsibility for policy and planning.

AIDS Advisory Committee

A professional AIDS Advisory Committee was formed in the early stages of the project **(See Appendix F for Membership)**. This Committee provided valuable program guidance and medical advice to the AIDS staff, and in the early days of the project before staff were hired took on some management functions. In the latter instance, the Committee initially met weekly rather then monthly and thus filled a gap in the organization of the project.

Towards the latter part of the second year of the project, AIDS Project staff reported some confusion about the mandated authority of the Advisory Committee. At this time, new staff positions and more clearly defined roles and responsibilities within the GNWT Department of Health and its Medical Directorate and Community Health Divisions enabled management functions of the Advisory Committee to be assumed by these staff.

An attempt was made to revise the Terms of Reference of the Advisory Committee and to broaden its function to setting a direction for Territorial-wide programs. Regional representation was to be included in the membership. However, a Government financial restraint directive was initiated at that time and travel was restricted. Thus, the revised Committee never met and the Project Advisory Committee was informally phased out.

Nevertheless, in the early stages of the project, the Committee played a key management function, provided stability and direction for the project, and contributed to the development of the earliest written educational materials.

It also established strong linkage with other government departments and professional associations which were important to the promotion of AIDS awareness and the prevention of HIV infection. These linkages remain today.

Linkage with the Medical Directorate

The primary duties of the Medical Directorate are related to disease prevention, data collection and trends in disease, establishing protocols for testing for the infection and establishing protocols for medical treatment, surveillance of disease and for infectious disease control. The latter services included training of health professionals.

One of the objectives of the AIDS project was the training of professional staff. During the first year of the Project, the nurses received their education about HIV infection and AIDS at the project workshops.

However, it was the responsibility of the office of the Medical Director

"to provide current and accurate information about AIDS to the AIDS Project, the AIDS Coordinating Committee and health care professionals."

This the Medical Directorate did through a variety of functions: the Chief Medical Officer of Health, the Epidemiologist and the Infectious Disease Control unit. At first, this division of responsibility for the training of professional staff caused some strain between the project staff and Medical Directorate staff. However, over time, both groups played a role in keeping health workers up to date about AIDS.

Towards the end of the second year of the project, the AIDS Project Researcher position was transferred to the Medical Directorate. This staff person was able to assist the Epidemiologist with updating the Department of Health's Sexually Transmitted Disease Surveillance data-base.

Updating the STD data-base was one of the original objectives of the AIDS Project. The rates of sexually transmitted disease can be one indicator of the possible amount of HIV infection in a population. Therefore, it is important that this be an accurate data-base.

Project funds ($50,000.00) to accomplish this task were transferred from the AIDS Project budget to the Medical Directorate STD data-base project budget with prior approval from NHRDP, the funding agency.

Linkage with the Family Life Education Program and the School Health Curriculum

The Government of the Northwest Territories had two health promotion programs that linked with the AIDS Project. These were the Family Life Education Program, and the School Health Curriculum Project being developed jointly with the Department of Education. Organizationally, the AIDS Project was a special entity of the GNWT Health Promotion Program. However, during the early months of the project, the Co-ordinator for the Family Life Education Program was in charge of the AIDS Project until project staff were hired.

The Family Life Education Program had been established several years earlier to promote maternal and child health, and to talk in the schools about sexual health. This need for sexuality education and other health topics in the schools lead to the development of the Department of Health/Education School Health Curriculum. At the same time, emerging from the discussions about human sexuality were discussions about family violence. The program then shifted its emphasis to meet this growing need.

The three staff employed in this program were familiar with the communities in the Territories and in educating the public and professionals. Thus, they were loaned to the AIDS Project during the first 6-8 months of the project until the AIDS Project became established with its own staff. This close link between the two programs continued throughout the life of the project. Messages about the prevention of HIV infection became a regular part of the Family Life Education Program.

Access to Translation and Audiovisual Production Services

The AIDS Project could not have met some of its objectives without the support and services of the GNWT Department of Culture and Communications and the availability of private translating and production services. The Department of Culture and Communications provided translation services for audiovisual materials and arranged for the production of other materials. Delays in obtaining the required services often occurred largely because of a staffing shortage of translators or their unavailability during the sittings of the Legislative Assembly. In some situations a private translator was also contracted to do the work.

However, access to translation and audiovisual services is essential for the success of any health promotion initiative in the Territories. This principle could apply to other agencies trying to provide health promotion services to a multicultural and multilingual society.

Changes in Project Services and the Emerging of the Regional Delivery of AIDS Education Programs

In general, the major functions of the AIDS Project were to plan services and programs for all of the Territories, deliver these programs throughout the Territories, develop educational materials and provide advice and consultation to professional staff and community groups. This they were able to do along with the assistance of staff from Family Life Education, nurses, physicians and teachers.

Given the geographic vastness of the Territories, the delivery of these services to each community became an increasingly unrealistic task. At the same time, the new Regional Health Boards and services were becoming more able to take on their responsibility for the delivery of AIDS education programs and services. Throughout the life of the project, nurses in the community health centres were increasingly providing community groups and individuals with education about prevention of the infection and treatment of the disease. From 1990 to 1991, 28 Community Health Representatives had been trained in health education. Clerk interpreters were also becoming more educated about terminology related to HIV infections.

With these human resources and the educational materials produced by the project and from other jurisdictions in Canada, the Regional Health Boards and Services were prepared to take on increased responsibility for local and regional delivery of education services about HIV infections.

The Department of Health will retain its role in overall program planning for the Territories, establishing program standards and policy related to the prevention of HIV infections, treatment of disease, and surveillance for the numbers of cases of the infection in the Territories. Most of these activities will be done with participation from the Regional Health Board staff, the deliverers of HIV services.

The expectation is that each Regional Health Board will eventually employ its own Health Promotion Officer who will be responsible for education for their communities, working with community groups, special projects and initiatives, and developing local resource materials and people. They will consult with Health Promotion Consultants in Yellowknife who will each have a specific area of expertise, including the prevention of HIV infections. All regional health centres have started to exercise this new responsibility.

CHAPTER 3

PROJECT ACTIVITIES AND INITIATIVES

COMMUNITY INITIATIVES

Community initiatives address the objectives:

> "promoting community involvement and ownership of HIV prevention and management by provision of information on-site (in local or regional workshops)"

and: "promoting and supporting unique community projects regarding HIV prevention and education."

They include both those activities originating from professionals and directed towards involving the community as well as those activities originating directly from the community itself.

Community Presentations and Workshops

To achieve the objective of promoting community involvement and ownership of HIV prevention, the NWT AIDS Project provided presentations and workshops to community groups. Correspondence on file indicates that these were arranged in cooperation with local health care professionals or community groups. Various groups were informed of the availability of resource people from the Project, but specific arrangements were made only on request of local individuals or agencies. Later correspondence suggests that requests were screened to ensure that a local person or agency would co-ordinate and organize the workshops, that specific groups would be targeted and that a local person or group would follow-up with continued AIDS education following the workshop. This was to ensure community commitment and involvement.

There is no single and concise record of all the workshops and presentations given. Information in **Appendix G** listing various workshops and presentations given has been derived from a variety of files. This includes files on trip reports, community presentations, summaries of participants' evaluations, and letters of "thank you" for presentations done. This Appendix therefore is not a complete list of all that was done but does represent a minimum outline. Number of participants was either as stated or taken from the number of evaluation sheets returned. This latter source would tend to underestimate the numbers.

From the table in **Appendix G** it can be seen that approximately 40% of these presentations were to school students. This was followed by public meetings, then college and adult education students, with both groups comprising about 20%. Presentations to correction centre inmates, community organizations and special events made up the remainder. Community organizations included groups such as Business and Professional Women's Association, Rotary Club, Girl Guides. Special events were health fairs and youth fairs.

Public meetings were less frequently used as a forum later in the project probably because, as correspondence indicates, they were sometimes not well attended. This would tend to support the approach of reaching people through existing groups.

Public Service Alliance of Canada Health and Safety Conference

The involvement of the AIDS Project and Family Life staff in the Public Service Alliance of Canada (PSAC) Health and Safety Conference is a prime example of collaboration with a community organization. AIDS was one component of a much broader program on workplace health and safety. The staff facilitated the segment of the conference on AIDS and the workplace using the materials and format developed by the PSAC as well as those of the GNWT Department of Health.

Uncle Gabe's Friendship Centre

A public AIDS conference was held at Uncle Gabe's Friendship Centre in Fort Smith on October 21 and 22, 1989. This conference was initiated, sponsored and hosted by the Friendship Centre, but with collaboration from the AIDS Project which contributed speakers and covered the costs of simultaneous translation. A total of 71 people attended the two-day conference. The theme of the conference was **"AIDS in the Community...What If?"**.

Local Radio Shows

Radio phone-in programs are another means of generating interaction with communities on a particular issue. While visiting the communities, AIDS Project workers and Family Life Education staff sometimes were able to arrange to be on local radio phone-in shows.

From the trip reports on file, there is documentation of staff participating in the following radio phone-in shows:

09-Aug-89	Arviat Radio Phone-in Show	(7 calls)
16-May-90	Lake Harbour Radio Phone-in Show	
14-Jun-90	Aklavik Radio Phone-in Show	(10 calls)

Community Displays

Displays attended by a resource person also offer an opportunity for community interaction and education. Such displays may be a single activity such as a display in a shopping mall or part of a large event such as a fair or conference. Both forums were utilized by the AIDS Project staff. Displays were set up in conjunction with larger events such as the Arviat Youth Conference in August, 1989 and the Coppermine Health Fair in August, 1990. At both, a combination of displays and presentations on HIV/AIDS were used at events for which the overall theme was much broader than just HIV/AIDS.

World AIDS Day

Each year for World AIDS Day (December 1), the AIDS Project staff were actively involved in setting up and manning a display in the Panda II Mall in Yellowknife. The themes were "Let's Talk about AIDS" in 1988, "Youth and AIDS" in 1989, and "Women and AIDS" in 1990. The displays included posters and enlarged copies of newspaper articles, as well as distribution of buttons, pamphlets and condoms. The 1988 display included video showing of the public service announcements; the 1990 display included a distribution of promotional coasters and "Proud Pete" booklets.

The numbers of people stopping at the displays were 70 in 1988, 109 in 1989, and 59 in 1990. Women consistently exceeded men by two to one, and during 1990 when the theme for World AIDS Day was "Youth and AIDS", the proportion of teenagers was much higher than in previous years.

In the first year (1988), awareness of World AIDS Day was also promoted through newspaper advertisements and radio interviews. In 1989, a presentation at Stanton Yellowknife Hospital was also held in conjunction with World AIDS Day. Media attention was generated through a press release, a dramatization of the radio spots produced by the Native Theatre Group, and the release of the locally produced radio drama, "Charlie's Last Homecoming." **(See page 27, "Radio Drama".)** Copies of this radio drama, as well as the CPHA video, "AIDS: The New Facts of Life," were distributed to all high schools in the Territories.

To promote involvement in World AIDS Day in all communities, Project staff also provided materials and suggestions to the health centres and public health units throughout the Territories. In 1988 support to the other communities consisted of distribution of posters in English and Inuktitut. The next year, in response to encouragement of Regions to undertake local initiatives in observation of World AIDS Day, requests for materials came in from 29 places with a total of 4,025 English and 3,185 Inuktitut buttons and 50 posters being distributed.

Individual Counselling

Although it is not well-documented in the files, it is known that the AIDS Project staff provided individual face-to-face counselling about HIV/AIDS. This took place both in the office in Yellowknife as well as during field trips to other communities.

Concurrent Department of Health Initiatives

During the two fiscal years 1987-88 and 1988-89, the Family Life Education Consultants (FLECs) undertook an extensive program of AIDS education in the communities as indicated by the summary of the workshops that they conducted. The FLECs were frequently involved in individual counselling on HIV/AIDS during these field trips.

The FLECs and AIDS Project staff met on a regular basis to co-ordinate their efforts. The FLECs kept the AIDS Project staff informed of all their activities via the "Community Checklist" form. On this form they reported a brief description of all presentations given, the contact person and number of participants. This form was also used to record other community contacts made during that visit.

The doctor working out of Cambridge Bay at this time also used this "Community Checklist" to report back to the AIDS Project on his educational activities during community visits. He appears to have been the only person other than the FLECs who kept the AIDS Project informed of independent educational initiatives in the communities. Correspondence on file suggests, however, that various health centres were stimulated to undertake on their own a variety of AIDS educational activities. Unfortunately, there is no indication of the extent of these local initiatives.

TRAINING

As used in this report, training includes all activities designed to assist people to acquire the knowledge and skills required to carry out their work. This includes professionals and non-professionals, people directly or indirectly dealing with HIV/AIDS in their work, and elected or appointed policy makers.

At the beginning of the project, professional training came under the mandate of the federal Medical Services Branch. Following transfer of health services to the Government of the Northwest Territories, it became part of the mandate of the Medical Directorate. Despite this, the NWT AIDS Project continued to have a responsibility in professional training for the entire life of the project. This was shared with the Medical Directorate.

One of the objectives of the NWT AIDS Project was

> "providing training for a variety of groups - volunteers; health, social service and education professionals; managers; 'first response' personnel (e.g. ambulance attendants, fire fighters, etc.); and others."

In addition to meeting this objective, the Project also undertook training as a means of achieving the objectives:

> "establishing as a priority the training of native people who can provide information and counselling informally in communities and in a native language"

and: "promoting and supporting the development of appropriate public and governmental policies on HIV, and providing co-ordination, assistance and expertise to expedite policy development and appropriate follow-through."

Presentations and Workshops for Professionals and Others

Throughout the project, the AIDS Project staff provided numerous presentations and workshops to professional groups and others who would be faced with coping with the issue of HIV/AIDS in their work. From the information on file it appears that the Project staff took an approach similar to that used with community groups by stimulating requests for their service and responding to requests. They did, however, appear to take a more proactive approach in identifying potential professional groups and in stimulating them to recognize a need to prepare themselves to cope with HIV/AIDS.

Information on these presentations and workshops was derived from the same sources as that for community groups. This is summarized in **Appendix H** and represents a minimum of what was done, but in no way can be considered to be all-inclusive.

AIDS in the Workplace Videoconference

A unique approach within the area of professional training was the "AIDS in The Workplace Video-conference" which focused on AIDS in the workplace policy development. It was co-sponsored by Sheridan College in Ontario and the Federal Centre for AIDS, and was broadcast live and received simultaneously at various locations across the country. The NWT AIDS Project was involved in the organization of the Yellowknife link-up and facilitation of local discussion groups. The 60 people attending in Yellowknife included representatives from government departments, non-profit agencies and private industry.

Although the response to the conference appeared to be positive, no information is available on how many participants afterwards attempted to develop or completed such a policy for their own workplace. A follow-up questionnaire to participants at a later date would have provided valuable information on the impact of the conference.

GNWT Policy on AIDS in the Workplace

The Project staff provided technical expertise to the GNWT Department of Personnel in the drafting of a government policy on AIDS in the workplace.

AIDS Project Open House

On March 22, 1989, the NWT AIDS Project held an inter-agency open house. The purpose of the open house was to establish contact with the various agencies, both governmental and non-governmental, which might have some direct or indirect concern with HIV/AIDS, and to make them aware of the resources available through the AIDS Project. Twenty individuals had signed the guest list.

Release of the NWT Report of the Canada Youth and AIDS Study

The Department of Education worked in collaboration with the AIDS Project staff to arrange for the release of the NWT Report of the "Canada Youth and AIDS Study." This report was released on April 19, 1989 in a workshop designed not only to disseminate the results of the study but also to explore the implications for the NWT and to begin developing Territorial strategies. As part of the strategy, a decision was made to distribute a locally produced audio drama, "Charlie's Last Homecoming", to all high schools in the NWT. This audio drama was originally produced for radio.

AIDS Component of the School Health Curriculum

The NWT Department of Education developed a component on HIV infection as part of the school health curriculum for grades 7, 8 and 9. From the meeting minutes of the AIDS Co-ordinating Committee (ACC), it appears that the curriculum was developed by the Department of Education and reviewed by the committee. Other than the Co-ordinator in her capacity as member of the ACC, the AIDS Project staff were not directly involved in the development of this curriculum. However, the Family Life Education staff did assist. The AIDS Project staff were later involved with the training of teachers to prepare them to teach about HIV/AIDS in the classroom and in the release and use of the NWT Report of the "Canada Youth and AIDS Study" as discussed previously.

Yellowknife AIDS Resource Network

During the first half of 1990, attempts were made by the AIDS Project to establish an association of NWT professionals whose services may be required by people living with HIV/AIDS. The purpose of the Association was to prepare in advance for how the needs of people with HIV/AIDS would be met in the NWT. Reply cards had been printed for mail-out to prospective participants, but they were never mailed out due to staff changes. Information on the groundwork done on this initiative was passed on to the Mackenzie Regional Health Service.

HIV Infection and AIDS - Information for Health Professionals

The manual entitled "HIV Infection and AIDS: Information for Health Professionals" is commonly known as "the burgundy binder." This manual, disseminated in February, 1990, was produced by the Medical Directorate as an update of a 1988 document prepared by the federal Medical Services Branch prior to transfer, with the NWT AIDS Project offering their suggestions during the development of the manual. These suggestions included having its pamphlets translated and available in audio cassette format. The Medical Directorate considered this, but due to the lack of translators, it was not implemented.

AIDS Update Newsletter

The first two issues of the "AIDS Update" were put out by the AIDS Co-ordinating Committee in May and July of 1987. The purpose of the publication was to keep health professionals and interested others abreast of the emerging information on HIV/AIDS, its relevance to the NWT, and details about the AIDS Project.

The AIDS Project staff continued this newsletter, producing 5 issues between October, 1987 and February, 1989. These newsletters were distributed to health centres, regional health boards, CHR's, and counterparts elsewhere in Canada, among others. When the Minister of Health adopted the practice of making periodic statements in the Legislative Assembly with updated information about HIV infections in the Territories and the activities of the Project, there was less perceived need for such a newsletter and it was discontinued.

Outside Presentations

Some of the staff were also involved in presenting papers about the NWT AIDS Project at national conferences. Presentations were made at the following conferences:

Canadian National AIDS Conference on "Uniting Perspectives for Prevention and Caring in the Community", in Toronto on May 16, 1988

First Canadian Conference on AIDS and Related Issues in the Native Community, in Vancouver on April 14, 1989.

Circumpolar Nursing Conference in Whitehorse, Yukon on May 18, 1990

In addition, one of the CHR's involved in the 1990 Door-to-Door campaign made presentations at both the First Aboriginal Conference on AIDS in Vancouver and at the NWT CHR Conference in the spring of 1991.

National HIV Strategy

The NWT AIDS Project staff provided input into the development of the National HIV Strategy.

EDUCATIONAL MATERIALS

Another major objective of the NWT AIDS Project was to produce and distribute HIV educational materials (print, audio, and audio-visual), which were translated into the aboriginal languages and culturally relevant for NWT residents.

A wide range of materials are included under the category of "educational materials", ranging from print to audio-visual format, and they were used as both an adjunct to professional teaching and alone as in the media. The following summarizes the various educational materials developed and disseminated by the AIDS Project.

Pamphlets

The first pamphlets developed by the AIDS Project were a series of three facts sheets entitled "The Facts on AIDS", "Safe and Less Safe Sex", and "Protecting Yourself Against AIDS". A pamphlet stand was also designed for displaying the pamphlets. In August, 1987, the pamphlet went to print with 10,000 English and 2,500 Inuktitut being printed. They were distributed in October to health centres, physicians, schools, social service departments, adult education centres, libraries, regional health boards, band councils, and settlement/hamlet/town councils. One year later supplies had been used up and a reprint was initiated to meet requests from the communities.

The AIDS Project had been planning to design a new pamphlet on AIDS and HIV. Early drafts of pamphlets on general information about HIV infections and on the use of condoms are on file. Some of these ideas were incorporated into a pamphlet on AIDS being developed by the GNWT Health Promotion staff as one in a series of five pamphlets for the Door-to-Door Campaign. Although the Health Promotion staff developed this pamphlet in order for it to match the others in the series, funding for the production of it and another pamphlet on STD's came from the AIDS Project. There were 18,000 pamphlets produced on each of these two topics and distributed at the time of the Door-to-Door Campaign.

Posters

A poster with the caption "Stopping AIDS is Up to You" was produced and distributed in conjunction with the first AIDS pamphlets. The poster was produced in ten languages with 500 English, 300 Inuktitut and 100 each of Chipewyan, Dogrib, Gwich'in, North Slavey, South Slavey, Inuvialuktun, Inuinnaqtun and French being ordered. In addition to the mail-out of the posters in October, 1987 along with the pamphlets, arrangements were made in 1988 to have the poster displayed at all airports in the Territories.

Feedback on this poster collected by the AIDS Project at the Regional conferences in the autumn of 1987 indicated that there was some question on the meaning of the design. The partially hidden face with only a pair of eyes showing was perceived by some to be "lurking", "sneaky" or "scary".

In line with some suggestions received along with the feedback on the first poster, a second poster was produced in the autumn of 1988. This poster was similar in layout to the first but used the caption "Stopping AIDS is Up to Us" and showed two young people talking with an elder. This poster was also produced in ten languages with all those other than English in a bilingual format. They were printed in quantities of 300 English only, 600 Inuktitut, 200 South Slavey, 125 each of Dogrib, Inuinnaqtun and Inuvialuktun, and 100 each of North Slavey, Loucheaux, Chipewyan and French. One of the places where this poster was sent for display was to the liquor stores in the Territories. By March of 1989, the Project was looking at reprinting some of the languages to meet the requests both from within and outside the NWT.

Buttons

Buttons with the slogan, "Stopping AIDS is Up to Us", were designed to match the pamphlets and posters. These were produced in both English and Inuktitut.

Coasters

Bar coasters in two colourful designs with the slogan "Practice safer sex: Use a condom" were produced in 1990. A supply of 10,000 were printed and samples were distributed either directly or through the public health nurses to various establishments with liquor licenses. Reactions from these establishments varied. One restaurant manager wrote that although he was generally supportive of the idea, he felt that they were not appropriate for his type of establishment. A few places in Yellowknife did obtain and use a supply of the coasters, but none followed through to use them regularly or to purchase an on-going supply of them.

Newspaper Advertisements

The following summary of advertisements placed in Northern newspapers between 1987 and 1989 has been taken directly from the AIDS Project files:

> The NWT AIDS Project has produced approximately 75 advertisements which have appeared in 11 Northern newspapers between October 15, 1987 and July 31, 1989.
>
> There are 7 weekly newspapers and 4 bi-weekly newspapers in which the NWT AIDS Project has advertised. The English language ads have appeared in: News North, The Yellowknifer, The Weekender, The Hub, Nunatsiaq News, The Inuvik Drum, The Slave River Journal, The Native Press, and the Mackenzie Times. The Native language ads have appeared in Nunatsiaq News and Tusaayaksaat. The French ads have appeared in L'Aquilon.
>
> Between October 1987 and July 1989, we have advertised in almost every issue of the newspapers listed above; close to 800 HIV/AIDS ads have circulated in newspapers across the North.
>
> On the next page is a breakdown of the following fiscal years:
>
> October 15, 1987 - March 31, 1988

Newspaper	**87/88 Placements**	**88/89 Placements**	**89/90 Placements**
News North	22	52	16
Yellowknifer	22	52	16
Weekender	22	52	16
Hub	22	52	16
Nunatsiaq News	22	52	16
Inuvik Drum	22	52	16
Slave River Journal	22	52	16
L'Aquilon	11	26	8
Native Press	11	26	8
Mackenzie Times	11	26	8
Tusaayaksaat	11	26	8
TOTAL	**198**	**468**	**144**

TOTAL 1987-1989 810 Newspaper advertisements

(source: AIDS Project files)

Each week a new message was used. These messages are outlined in **Appendix I**.

During that time only a few of the advertisements received negative feedback from the community. The one which began with the words "drunk and horny", printed in early 1988, received the most reaction. Some considered the language offensive and inappropriate for a community newspaper. This illustrates the dilemma of trying to reach specific groups in their own terms through a medium which reaches the general public.

The AIDS Project also advertised the availability of the AIDS Hotline services through the classified ads in a number of local newspapers. When this began or how extensively it was advertised has not been recorded.

Other work with the newspaper media was also undertaken, although not specifically educational materials production. This includes interviews given to newspaper reporters, and analyzing and strategizing reactions to newspaper articles. A note on file indicates that as of December, 1988 there had been approximately "90 pieces on or about AIDS .....published in northern newspapers." During the next two years, a similar number were also printed. Some of these articles had been stimulated by the Project, either through the interviews or through press releases and press conferences of the AIDS Project.

Radio Advertisements

The AIDS Project produced two sets of radio PSAs and was arranging a third set as the Project came to an end. This third set has been completed by the Health Promotion Section of the Department of Health. The first set consisted of six different 28-second PSAs produced in 1988. They were produced in six languages (English, Inuktitut, South Slavey, Gwich'in, Dogrib and Chipewyan). It appears that there had been plans to also have them translated into Inuvialuktun and North Slavey but that this was not completed due to the unavailability of qualified translators. There were no plans to translate the PSAs into Inuinnaqtun because no commercial station broadcasting in Inuinnaqtun was available. These ads were run by CBC over a three-month period from September to December, 1988. The English spots were broadcast on CJCD over a longer period of time and CKNM had also used them intermittently.

The set of radio PSAs produced in 1990 was comprised of 14 messages. There is no indication whether these announcements were translated, nor where or how often they were aired. Attempts were made to obtain this latter information from CJCD and CKNM, but no reply is on file.

Early in 1990, a request had gone out for proposals to write and record radio announcements and a radio play in both English and Inuktitut. No proposal was accepted, and another request for proposals went out in July of that year. Following a long period of negotiations, a successful contract was awarded, but for the production of the radio PSAs only and not for the radio play. The contract began in December of 1990 and was to be completed by March 15, 1991. With the change in AIDS Project staff during this period, the Health Promotion Section took over this project and completed it in 1992.

In addition to the public service announcements, the AIDS Project staff were also involved in doing radio interviews and radio phone-in shows. As discussed under community initiatives, some radio phone-in shows were done on community radio in conjunction with other community presentations.

Radio Drama

The Native Theatre Group was contracted by the NWT AIDS Project to produce a 30-minute radio drama about AIDS. The result was "Charlie's Last Homecoming" which was released in December, 1989 in conjunction with World AIDS Day. Copies of this radio drama were distributed to all high schools in the Territories.

As discussed in relation to the third set of radio PSAs, attempts were made to contract out for development of an Inuktitut radio play. Unfortunately, despite repeated requests for proposals, the efforts remained unfulfilled.

Television Advertisements

In 1988, the Inuit Broadcasting Corporation received the contract to produce ten television PSAs, in all the ten Territorial languages (Chipewyan, Dogrib, Gwich'in, North Slavey, South Slavey, Inuktitut, Inuvialuktun, Inuinnaqtun and French). The English versions were released in May but the native languages were not released until six months later due to delays with translations and back translations.

The titles or themes of the ten PSAs are:

- What is AIDS
- How is AIDS spread (showed a picture of dominos)
- AIDS is not spread by day-to-day contact
- What is safe sex
- Alcohol abuse and safe sex
- AIDS cannot be cured like other STD's
- Travelling to the south
- Protect yourself and your community
- Counselling and testing
- Compassion for AIDS victims

They were shown on CBC Northern Services, made available free of charge through video outlets in the Territories, and were available on loan to health centres and other groups who could use them in their programs.

Response both inside and outside the NWT was positive. The PSAs had been widely distributed throughout the rest of Canada with copies being sent to every Minister of Health in the country. Records indicate that at least fifty agencies outside the NWT had obtained a loan copy with a quarter of those indicating either utilization of them within their program or retention of a copy for future use. Some of the PSAs, especially the "domino" one, were used in Newfoundland, Nova Scotia, Ontario, and Saskatchewan.

AIDS INFORMATION LINE SERVICES

The AIDS Project set up and offered an AIDS telephone information service starting in October, 1988. Through this service, the public were able to obtain information and counselling anonymously over the phone. A toll-free number was made available to make the service readily accessible throughout the Territories and the line was answered by project staff during office hours. The number for the line was widely advertised throughout the Territories using the various media and printed materials.

Data from monthly reports are available on the calls received by the AIDS Information Line during the 30-month period from October, 1988 to March, 1991.

Office Hours Calls

During the 30-month period, 791 calls were received during office hours.

According to the monthly reports, it appears that the office hours were changed as of April, 1989 from 9 am to 12 noon and 1 pm to 5 pm, to 8:30 am to 12 noon and 1 pm to 5 pm. In the year-end summary for the period October, 1988 to March, 1989, the office hours are stated to be 8:30 am to 12 noon and 1 pm to 5 pm. It is not known if a comparable time period for office hours was used throughout the 30-month period.

During the period June, 1989 to March, 1991, there were 393 calls received during office hours which were unrelated to AIDS. It appears that these are not included in the total number of daytime calls because up until December, 1989 the unrelated calls exceeded the number of related daytime calls. After that date the number of related daytime calls exceeded the number of unrelated calls with the exception of March, 1990 when the numbers were equal. For that month, there are individual telephone counselling forms to substantiate that some AIDS-related calls were received. No calls during the 30-month period required translation.

There is a record of 291 individual telephone counselling sessions on file for the period September, 1989 to March, 1991. This is considerably less than the 652 daytime calls recorded for the same time period. If the total daytime calls does not include unrelated calls as discussed above, there are a large number of calls unaccounted for. Some of these calls might include professionals requesting information on patient protocols or procedures, which were referred to the Medical Directorate, or professionals requesting health promotional materials, which might have been recorded on a "Request for Information" form and referred internally.

The average length of a call was 6.5 minutes, based on those calls for which individual telephone counselling forms were completed.

After-Hours Calls

During the period from December, 1988 to February, 1991, a total of 119 calls were recorded as having been made during the lunch hour. From the year-end reports for the years 89/90 and 90/91, it appears that these calls have been included in the total number of after-hours calls.

After-hours calls have been recorded for December, 1988 and the period from May, 1989 to March, 1991, although some data is missing from March, April and December, 1990, and February and March, 1991 when there were problems with the answering machine. The total number of after-hours calls during the period noted above is 984.

Trends Over Time

Trends in the number of incoming calls were determined by comparing monthly averages for the five- to six-month periods during the operation of the information line as per the graph of the "Summary of Calls Received". **(See Appendix J)**

The average number of calls per month has nearly tripled during the two-and-a-half years of operation. During this same period, there has also been an increase in the number of after-hours calls and lunch-time calls, but not as great. The number of unrelated calls has been decreasing during this time.

Services Provided

All information available has been tabulated from the individual telephone counselling forms, so information presented here reflects only a small portion of the total calls as discussed above.

Presenting Problems

All presenting problems that arose during a counselling session have been recorded. That is, one caller might have had more than one presenting problem. Below is a list of the presenting problems with the frequency of occurrence shown:

transmission	32%
testing	22%
safer sex	13%
symptoms	12%
other support	10%
other STD's	5%
statistics	3%
treatment	2%

During the first year-and-a-half, the most frequently asked questions were about transmission, usually followed by safer sex. During the last year, questions about testing became the most frequently asked, followed by transmission and symptoms.

Referrals Made

Similarly, a caller might have been referred to more than one other professional or agency. The following list reports the frequency of referral to the various types of health professionals or agencies but does not reflect the proportion of callers referred:

physicians	40%
health centres	33%
other	10%
PHN	7%
family counselling	7%
psychiatric team	2%
social services	1%
alcohol program	1%
legal aid/lawyer	0%

During the first year-and-a-half, referrals were most likely made to the health centre first, then the physician. During the last year this switched, with more referrals being made to physicians and fewer to health centres. This change appears to coincide with the increase in questions about testing, but is probably more a reflection of the location of callers - that is, callers from a town with a doctor or a village with a health centre.

DEMOGRAPHICS OF CALLERS

All information available has been tabulated from the individual telephone counselling forms, so information presented below reflects only a small portion of the total calls as discussed above.

Estimated Age

From the month-end statistics, it appears that up until July, 1990 the teen group included ages 12 to 19 and that as of that month, the teen group was changed to 13 to 19. Examination of the individual telephone counselling records reveals that throughout, the youth group was given as "up to 12" and the teen group was given as "13 to 19" with age 12 not being included in either category. The following breakdown summarizes the month-end reports, recognizing that these two groups may or may not be comparable from one month to the next.

youth	3%
teen	26%
adult	71%

The majority of calls received from callers less than 12 years old occurred during the first six months with no calls from this age group after the first year. With the exception of a few individual months, adult callers have exceeded teenage callers. During the last 12 months, the proportion of teenage callers has declined.

Sex

For the duration of the project, the breakdown by sex for those callers on whom data is available is shown below.

male	55%
female	45%

There is no strong trend in the sex of callers over time. During the first and last six-month periods females exceeded males while during the middle year-and-a-half the reverse was true.

Sexual Orientation

There is insufficient data on sexual orientation to determine any meaningful pattern, with the orientation of 78% of the callers being unknown. The breakdown by sexual orientation as far as was recorded is as follows:

heterosexual	19%
homosexual	3%
bisexual	0%
unknown	78%

First Call

Information was collected from July, 1990 to March, 1991 on whether or not the caller was using the information line for the first time.

yes	69%
no	31%

As the information has only been collected for the last nine months, no trends are yet obvious.

Region

Information on the region of the caller was collected for nine months from July, 1990 to March, 1991.

Baffin	10%
Inuvik	4%
Mackenzie	38%
Keewatin	3%
Kitikmeot	8%
outside NWT	10%
unknown	28%

The majority of the calls from the Baffin occurred from November, 1990 to January, 1991, while all the calls from Inuvik occurred from September to November, 1990. There were no calls from Keewatin until December, 1990. Calls from Mackenzie and Kitikmeot were distributed over the nine-month period, with by far the majority of calls coming from the Mackenzie region.

Source of Phone Number

Information on where the caller got the phone number for the information line was recorded during the periods October, 1988 to March, 1989, and July, 1990 to March, 1991 (i.e. during the first six months and the last nine months):

newspaper	5%
phone book	28%
radio	2%
poster	2
coaster	0%
health professional	5%
television	28%
other	2%
unknown	26%

During the first period, the majority of callers obtained the phone number from the television. The second most frequent source was the phone book. During the latter period, the source was unknown in the largest number of cases. The most frequently recorded source was the phone book.

All reports of television being the source of the phone number occurred during the first six months. This happens to coincide with the higher incidence of young callers, particularly those under age 12. Television was not recorded as a separate category during the second period. There was only one unidentified "other" during the second period which may or may not have been television.

CHAPTER 4

PROJECT EFFECTIVENESS

INDIRECT INDICATORS OF CHANGE

We looked for information from related sources that might help to indicate how much change in sexual behaviour might be occurring. In particular, we sought signs from STD rates, pregnancy rates and condom sales as indirect measures of the effectiveness of the AIDS education messages.

Unfortunately, complete data was not available for any of these measures. The Department of Health is just completing a study of STD rates, but their findings are inconclusive so far. Drug stores and condom suppliers do not keep their records in a way that could yield useful information. No reliable data regarding pregnancy rates seems to be available. As a result, we were forced to rely on anecdotal reports for most of our conclusions. [1]

STD's

The Department of Health's study of STD's revealed that while gonorrhoea is down slightly, chlamydia is up slightly. The reasons for this are unclear. For example, the increase in chlamydia could be due to an increased ability to correctly diagnose and report the infection. The Territorial Epidemiologist concluded that no dramatic changes were apparent and that no relationship could be assumed between these STD rates and the AIDS education program.

There was very consistent agreement among the caregivers we interviewed that high STD rates continue in all parts of the NWT. Some nurses pointed out that the same patients keep returning with fresh infections, indicating very little change in behaviour, and often very little concern for their ailment.

Pregnancy Rates

High pregnancy rates among teens and young women are also still apparent. Lack of use of contraception may not be the only factor involved, however. It was pointed out to us that among Inuit girls, having a baby in the early teen years is considered normal, possibly even a status symbol to be desired. Certainly, there is no sign of decrease in either pregnancy or STD rates.

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[1] "We" or "us" referred to on this page refers to Kate Tompkins and Associates.

Condom Use

The information about condom use was less consistent. In most places, it seems that condoms are being used more frequently than previously. Some informants spoke of dramatic increases in their rate of consumption. Free supplies left for easy access in washrooms in places such as nursing stations and adult education centres seem to be the most popular places for communities to stock up. Most drug stores reported an increase in condom sales, and one gives them away free to whoever asks. Several schools and bars have installed condom machines.

In Hay River, however, the drug store sells very few condoms. Arctic College students seem to be less interested in condoms than other people in their communities, in spite of what is reported to be a high rate of sexual activity among students. This could be explained by the fact that students with a higher level of education are more aware of other forms of birth control available to them which they prefer to condoms.

While most nursing stations give out condoms, many people indicated that they felt uncomfortable going to nursing stations and preferred to either find condoms elsewhere or do without.

Community respondents were asked for their impressions of changes in condom distribution, teenage pregnancies and the incidence of STD's. Their comments are summarized as follows:

	Condom Distribution	**Teenage Pregnancies**	**STD's**
Don't deal with this in this agency	54%	6%	8%
Increased slightly	2%	10%	8%
Increased greatly	27%	33%	10%
Stayed the same	4%	31%	25%
Decreased slightly	0	4%	2%
Decreased greatly	2%	0	0
Information not available	50%	10%	19%

This picture seems to indicate that although condom use has increased, so have pregnancy rates, and STD's are the same as usual or increased. This could be interpreted to mean that although some people are wearing condoms, lots of other people are not and they are the ones presenting themselves with STD's and pregnancies.

It could also mean that while condom use is on the increase, there are enough times when even a usual condom wearer fails to use protection, thus contracting STD's and becoming pregnant.

It is also possible that people are forming their impressions from incomplete or inaccurate information. However, there were few noticeable differences in response patterns by occupation, with nurses leading the way in all responses, so it is likely that these impressions are in fact based on reliable observation.

An interesting discrepancy turned up in peoples' impressions of whose decision it normally is to wear a condom. 50% of women were likely to say "In this community, it is a man's prerogative to decide on condom use". However, only 2% of men agreed. This raises some questions:

> If men think that women are the real decision makers when it comes to condoms, and women think that men are, who is deciding? Is the responsibility being abrogated by both?
>
> Are men likely to feel disappointed when their women partners insist on condom use, thus indicating that they have no say in the matter?
>
> Are women more likely to raise the subject, with their male partners unwilling to even give the idea serious consideration, leaving their women feeling unable to influence the situation?

If future AIDS education is to centre around condom use, it would be useful to conduct a thorough sexual practices survey to determine how such decisions are made. Without such information, advice to use condoms for protection may go unheeded due to the cultural implications placed on the idea.

Sexual Attitudes and Behaviours

There is overwhelming agreement that the people of the Northwest Territories are denying any serious risk from AIDS. The prevailing attitude is that "this is not our problem". AIDS is, in the minds of a great many northerners, only a white gay men's disease, and "we have none of those kinds of people here". People insist that AIDS can not and will not happen to them or their communities. At the very least, "until there is someone in this community with AIDS, I don't have to worry about it". In any case, no matter what is wrong with me, "the nurse will fix it". So why worry? AIDS is not yet a reality for most communities and few people see themselves as being at personal risk.

Most common responses to the question "What changes have you noticed in sexual behaviours and attitudes?" were as follows:

- people talk more openly about AIDS	52%
- people know more about AIDS and prevention	48%
- people want to know more about AIDS	31%
- people are more likely to obtain condoms	38%
- people say they have changed their sexual behaviours	10%
- people seem more tolerant of gays	6%

Many informants have painted pictures of very dysfunctional communities. The one most frequent observation of all informants, is how closely sexual activity is linked to alcohol abuse. 100 % of the respondents indicated that the two seem to go hand in hand. In fact several people commented to us that attempting to distinguish between the two was almost impossible. Thus alcohol and the risk of HIV infection are closely related. To stop the spread of HIV infections we must look at ways to decrease alcohol consumption.

When asked "What types of sexual practices are prevalent in your community", the responses looked like this:

- multiple sex partners	98%	- unprotected sex	88%
- sex while intoxicated	100%	- anal sex	19%
- sex with strangers	77%	- oral sex	23%
- monogamous sex	50%	- vaginal sex	33%

A common response when asked about monogamous sex was "I guess there must some of that around".

The underlying impression is of profound depression. The composite picture we were given by many caregivers is of communities full of lost, confused people. Their denial of their personal risk is mixed with great fear. How can we even confront AIDS, when so many more immediate priorities assail us? Suicide, sexual assault, spousal assault - these are the concerns of today. How can we even see past these to a frightening tomorrow? It seems that many people know about AIDS but are paralysed and cannot face it. Hence, their attraction to the immediate and accessible pleasures.

Some caregivers indicated there is a widespread lack of accurate information about the body and that many people do not understand clearly the connections between their activities and their health. There also is some misinformation about AIDS, how we get it and who is at risk and who isn't.

Young People

There is some indication however that young people are starting to be concerned about their sexual activity. More young people than older people are talking about sex and about AIDS, young people are more likely to use condoms than are their parents. However, one caregiver commented that the young girls who have attended some sort of training session, such as an assertiveness course, will use lines such as "my body belongs to me only so I will look after it" and then go home to a violent man whose sexual abuse they cannot hope to avoid. The implication is that in spite of good intentions and information, the ability to actually control what happens to them is still an elusive dream.

Community Attitudes

Community leaders and caregivers have expressed great concern for their people. Most point to the prevalence of sexual activity and the dysfunctional nature of their lifestyles as reasons to fear for their safety. There is also concern that inadequate infrastructures are in place to handle the practicalities of an epidemic. For example, housing is already short, so that the burden of caring for ill people at home may be unmanageable.

Predictions of how people will react if and when AIDS is discovered in their communities vary from panic and ostracism of individuals and their families, to compassionate care and support.

When asked "What would happen if AIDS were known to be in your community?" respondents made the following predictions:

There would be:

- increased desire to know about AIDS	46%
- increased fear but no change in behaviour	40%
- widespread fear	46%
- widespread panic	27%
- an attitude of caring for victims and families	25%
- new initiatives for education programs	19%
- changes in sexual behaviour	17%
- "native justice" would look after the situation	6%
- little change	6%
- apathy	4%

Several caregivers expressed frustration that they as yet have insufficient support from their community leaders, some of whom do not see AIDS as their priority or their problem.

Some blame for this lack of support has been placed on the Government of the Northwest Territories. Indecision from the Department of Health and a perceived lack of regular information flow about AIDS have apparently caused many people to assume that AIDS is no longer a concern.

Several people indicated that if the general public knew there was a person with HIV/AIDS in the community they would become much more careful. In fact, several caregivers urged that at the very least HIV/AIDS incidents be identified by region and preferably by community.

In summary, very little change in sexual behaviour has been reported, except perhaps among some young people. While caregivers and some community leaders are very concerned about the safety of their people, most individuals deny any risk to themselves or their communities from AIDS.

Community Initiatives

The most frequently mentioned AIDS education activities taking place in the communities were the work of public health nurses in delivering seminars to various community groups, and the use of the health curriculum in the schools. This was not always the case however, with some public health nurses reluctant to take initiative without more support from their communities, and some schools declining to include the AIDS portion of the health curriculum because it deals with sexuality.

One hotel plans to install a condom machine. Several bars and schools have taken the same step. A gas station in Rae provides free condoms with a fill up. Most friendship centres are involved in some proactive programming, including activities such as dispensing AIDS information along with alcohol counselling, handing out condoms, providing co-ordination to local agencies and sponsoring a local AIDS conference.

The Kitikmeot Region has plans to sponsor a speaking tour by an Inuit woman with AIDS. Arviat has launched an innovative program which uses health promotion information, including AIDS as well as smoking and nutrition, to teach literacy skills. Ingamo Hall in Inuvik has the public health nurse in periodically to lead workshops with their recovering alcoholic groups. A druggist in Iqaluit dispenses free condoms at his own cost and runs a continuous advertisement, at his own cost, in the local newspaper, warning of the risks of AIDS.

The Arctic Diocese of the Anglican Church has taken the initiative to ensure that its clergy are well-informed and that AIDS is being discussed in the local parishes. The Anglican Church in Fort Smith held a series of sessions led by a local doctor. In Pangnirtung, the Anglican Clergy developed and delivered a workshop for men only on the subject of love, sex, marriage and relationships. The Roman Catholic Church has held information sessions for its Central Arctic Clergy.

A few people have expressed dismay that the Department of Health has not supported their proposed initiative. Most agree that effective AIDS prevention will have to originate from the communities themselves, but there is a call to the Department of Health to act as catalyst or co-ordinator to facilitate that process.

Respondents were asked "What type of support is needed to help leaders develop as resources for their communities?" The responses most frequently chosen were:

- training (38%)
- educational materials (36%)
- consultation (25%)
- assistance with planning and development (36%)

Most frequent responses to the question "What is the most important need the community has right now with regards to AIDS?" were:

- more training for community caregivers (18%)
- more people qualified to provide information (24%)
- better access to current AIDS information (20%)
- more concern about seriousness of epidemic (44%)
- more responsible sexual behaviours (24%)
- more knowledge about how to prevent infection (22%)
- more education materials (13%)
- better educational materials (16%)
- information about the local epidemic (13%)
- more openness about talking about AIDS (13%)

When asked "What gaps exist in the community now with regards to AIDS education", the most frequent responses showed this pattern:

- information and education (55%)
- appropriate educational materials (29%)
- training for community caregivers (29%)
- access to current information about AIDS (19%)
- access to information about local epidemic (17%)
- counselling re prevention (14%)
- education services aimed at particular groups (12%)
- assistance developing policies (7%)

There was one significant trend that should be noted in these results: concern about the seriousness of the epidemic was most likely to come from nurses and from people with more than 5 years residency in their communities. The implication is that people who are most knowledgeable about their communities are concerned.

Recent arrivals basing their opinions on what they know from the south and voicing unrealistic fears are not the ones who are calling for stepped up AIDS action; it is the long timers and medical health care professionals.

EDUCATIONAL MATERIALS

Considerable concern was expressed over the perception that the AIDS education program seems to have been abandoned. Among those who had been around long enough to even be aware that there had been an AIDS Project, there was consistent dismay. The following quote is typical of the opinions expressed:

> "During 1987/88 there was a great deal of information. Since 1988 there has been nothing from the NWT and very little from anywhere else that has filtered into the community. The message out of Yellowknife is that this is no longer a great concern, yet we believe it is a great and growing concern."

This reduction in public profile seems to have lead to a marked level of complacency on the part of the general NWT population. It was not uncommon, during the research, to strike upon a conversation on the subject of AIDS only to discover that people considered the problem to have either gone away or have diminished to the point of little concern. While professional caregivers are more likely to be aware of a continuing risk, the general public's attitude seems to be: "After all if the government is no longer concerned then the problem must be under control."

Equally important are reports of a creeping spread of misinformation. For example, in Iqaluit, a community with the most apparent public concern over AIDS, otherwise knowledgeable persons commented that they understood that people who got the HIV virus very seldom ever developed AIDS and therefore the chances of getting AIDS was extremely low.

Several people commented on AIDS information that reached their community via American television stations, particularly the Detroit stations. Unfortunately, because the programs originated in the south and there were no concurrent northern images or messages, this only helped to reinforce the message that AIDS is a southern problem and has nothing to do with the north, particularly native people.

About 70% of the informants we interviewed could recall seeing something relating to AIDS, but very few could recall any of the specific materials [2]. However, very strong agreement was expressed about which materials were most effective and about what types of media in general should be avoided.

Print Materials

The weakest link in the information distribution chain was the print material. There was overwhelming agreement that print materials such as pamphlets are not effective (95% of respondents). Regardless of the language in which the material was produced it was seldom read. There was simply too much crammed into too small a space. Without illustrations (pictures, cartoons, etc.) there was nothing to attract people to read the material.

Most informants commented that either pamphlets are not read at all, or else if people do read them, by and large they do not adequately understand the words. Some commented that most people do not pay any attention to written materials, and may not even notice them in a passive display. A low literacy rate was pointed to as the main factor in the ineffectiveness of written materials.

However, several people advocated a cartoon or comic book format, especially using identifiable northern characters, similar to "Super Shamoo", if print materials were to be used at all. The focus must be on pictures or graphics, with as few words as possible.

The cartoon flipbook "Proud Pete" was given special acclaim. Though not one of the materials produced by the GNWT, it deserves special mention as a model of the type of print materials which people found useful. Its focus is humour, and everyone immediately understands the message, regardless of language or cultural background. "Proud Pete" was mentioned more often than any other educational tool.

The GNWT's purple and white pamphlets were in evidence in many places, but primarily because they are not often picked up from passive displays. One adult educator said that she had the same 20 or so pamphlets on display for at least two or three years and thought that no more than one or two had ever been picked up. The complaints were usually about the reading level required, but some also pointed to the alarming graphics and colours, which are not appealing to prospective readers. No one found these useful or helpful in their work.

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[2] It must be remembered that in most cases informants were being asked to recall events that had occurred 6-8 months earlier, and in some cases years earlier.

The materials developed for the door-to-door campaign were better received. Their strongest features appear to be the graphics, which are easily understood, and the simplicity of the language. Some people did remark that the graphics were bold and left little to the imagination, which was distasteful to some, but these were the same features which arrested people's attention. A criticism of the materials was that some reading was required to fully appreciate the message. Some informants reported that many people did not read the pamphlets at all, pointing either to language difficulties or to lack of interest in the topic as reasons.

However, in spite of some praise for the materials, there was a great deal of negative feedback regarding the delivery of the door-to-door materials. In many cases, the materials were simply left on people's doorsteps, with little or no follow-up or personal contact of any kind. This was not the procedure in every community, but does appear to have been the norm. Former AIDS Project staff commented that training for the door-to-door campaign was difficult, as the local communities had complete control over deciding who would be selected for the task. Not everyone was motivated to complete either the training or the delivery Job and some of the delegates did not even show up for the training provided by the AIDS staff. Some of the AIDS staff apparently were not in full support of the door-to-door campaign, but were obliged to execute it because it was initiated by the minister. Complaints were that it was unworkable and not the most appropriate choice for the moment. It does not appear however that this less than enthusiastic endorsement affected the results of the door-to-door campaign.

Video Materials

Videos were mentioned frequently as being a very effective way to get across the AIDS prevention message. It was suggested that a "made in the north" video be developed using northern actors, possibly elders, as the main characters. Several suggestions were offered regarding distribution of videos to make them easily accessible to people who need them, including supplying free copies at video outlets and adding a cartoon type trailer to a feature video at community screenings.

Television Ads

About half of the respondents recalled seeing TV ads, but many could not remember where these had come from. Some people knew of ads originating on imported TV stations. Only one person could describe the content of a TV spot, and it was from the United States.

Personal Contact

Personal contact was cited by many as being the most effective approach. Having a person with AIDS speak, especially someone from the region, was suggested as the number one education tool. The personal connection is the one most likely to reach people. Many spoke of meeting Leetia, an Inuit woman with AIDS, or seeing her speak in Inuktitut on TV as being the significant event which caught their attention and opened their eyes to the reality of AIDS risk in their personal lives. Her visits to the communities were funded by the Department of Health, Regional Health Boards, Hamlet Councils and community groups.

Radio

Community radio was also recommended frequently as a popular communication medium in most places. The radio ads, recalled by only a quarter of respondents, received very positive comments from broadcasters who aired them. One executive told the researchers that when he presented the tapes to his staff for their review, the frankness of the ads made some people squirm but that they gave resounding support to their airing. A few, he reported, had technical quality problems which made them unsuitable for play, but most were given air time. No records are available of radio or TV airing frequency [3].

We also encountered only one person who recalled "Charlie's Last Homecoming" when it was aired. However, one adult educator from the Kitikmeot region had obtained a copy of the tape from a friend and found it very useful in her adult upgrading class as a teaching aid. She was so impressed that she hoped to obtain a copy of the script to use in her English classes. Charlie's Last Homecoming was aired twice by CBC, CKNM and by CJCD.

Posters

The posters, "Stopping AIDS Is Up To You" and its replacement, "Stopping AIDS Is Up To Us" were also well received. (91% of respondents had seen them). The researchers saw the "...You" poster in several locations in every community we visited. We were puzzled however, that the "...Us" version is much less evident. In fact, the only place we saw the "...Us'' poster was in Yellowknife. The reason for this is unclear.

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[3] The Department of Health disagrees with this statement. See pages 26-28, "Radio Advertisements", "Radio Drama" and "Television Advertisements".

The first poster, "Stopping AIDS Is Up To You" was handed directly to seminar participants in their own communities. The second, "Stopping AIDS Is Up To Us" was mailed to names on a contact list, many of whom had little or no direct contact with AIDS staff nor had attended an AIDS seminar. Thus the people who received the first poster had more personal motivation to display the posters in their communities than did people who were contacted only by mail.

The other difference between the posters is their graphic design. "...You" was described by some as being negative because it seems to display fear and hiding. However, others described it as being intriguing, and because only the eyes could be seen, it could be anyone. Some thought the eyes were those of a child, evoking protective responses from viewers. The most frequent description offered of the "...Us" posters was "innocuous".

Friendship centres in the western NWT often displayed posters which were produced specifically for Indian peoples. Reports of friendship centre staff were that these materials were well received by their clients.

Newspaper Ads

The newspaper ads received a great deal of praise. Although only half of the respondents recalled seeing them, those who did spoke highly of them. Informants who were shown the ads and asked for their opinions had substantial praise. A marketing expert, new to the north, commented that several of them were very direct and bold.

HIV Information for Professionals

The "Burgundy Binder" for nurses received some praise from those who knew of its existence and who had read it. Many nurses were unaware that such a document had been prepared for them. Frequent turnover appears to the factor at work in this case. The one nurse we interviewed who used the binder on a regular basis is a long time resident of her community. One nurse said she was aware there was a copy somewhere in her station, but in her two year tenure she had not had time to read it and had not considered it a priority to do so, as no active HIV+ cases had yet surfaced in her community.

School Health Curriculum

The AIDS portion of the health curriculum received good reviews from evaluators, but it is not always used. There seemed to be two reasons for this. Some schools do not wish to teach anything which involves sex education. In other schools, there were teachers willing to teach the unit who did not feel well enough informed.

In most cases, parents supported the use of the AIDS portion of the Health curriculum. In Fort Smith, there was some concern initially about the Unit, but this quickly subsided and now it enjoys the support of most parents. The Department of Health reports that only about 40% of schools use the curriculum unit.

Of possibly greater significance in the long term is the work undertaken by the Arctic College Teacher Training Faculty who have developed a special program to prepare northern teachers to teach the curriculum in the schools. Reports indicate that even at the practice teaching level these northern trained teachers are more comfortable with the subject material than the majority of their southern trained colleagues.

Other Information Sources

Bar coasters were mentioned by four people, and buttons by 15. Only 3 people, however, rated them as being "most useful" in transmitting the AIDS message. The Anglican Church was commended by several clergy for the church's efforts to keep them well-informed.

Marketing Strategy

There was quite a bit of discussion regarding the way in which the AIDS educational materials were scheduled for public consumption. One senior management staff person described a sophisticated marketing plan which other former AIDS Project staff denied existed. Some staff commented that newspaper ads were withdrawn when money became short, with the idea that further publication of the ads could lead to overexposure, as well as being too expensive. The idea was to reinstate the ads at some point, but this was never done.

One staff person believes that the radio stations had complete control over airing schedules, which were completely out of the hands of the AIDS staff. However, according to an outside consultant who worked on developing the radio ads and "Charlie's Last Homecoming", no specific steps were taken to deal with the requirements of the broadcasters who would air the ads nor an exposure plan developed. The consultant commented that he warned the Department of Health that they would have additional hurdles to work out with the broadcasters, but that apparently no one knowledgeable took on that responsibility, possibly due to the instability of the AIDS unit and its staff turnover at the time. The posters were given out until they ran out, as were most pamphlets.

Several former AIDS staff very clearly expressed their dismay and disapproval of the cessation of visible educational and advertising activities. Words such as "inexcusable" and "ludicrous" were used in assessing the lack of long-term strategy for public education and the eventual abandonment of public education [4].

> "There was no marketing plan. Either nobody thought of it, or else staff turnover and funding cuts occupied peoples' imaginations too much."

An independent marketing expert commented that concern regarding saturation of the market does not apply when the subject is critical behaviour change in such a tumultuous climate and when the stakes are so high. He noted that to withdraw advertising after a short period of time creates only the impression that the scare is over, leading to apathy and no behaviour change.

Distribution of Materials

Few people had an opinion regarding the distribution of educational materials by the Otto Schaefer Library. Only a quarter of respondents had ever attempted to order any materials. Their satisfaction with the process was varied. A few people mentioned having requested pamphlets in the past year or so and being given only two or three as samples and expected to pay for any additional copies they desire. They expressed dissatisfaction with this arrangement, saying they expected the Department of Health to provide educational materials for free, as the Federal Government did before transfer.

Most people however were unaware that materials were available or were not interested in those materials supplied by the Department of Health due to their inappropriateness of language and style. A couple of nurses commented that the videos supplied by the Otto Schaefer Library are outdated, citing examples available from other sources as being more suitable for their clients and patients.

One half of the nurses interviewed remarked that the newsletters they once received were valuable and wished to have them continued. Eight other caregivers had seen the newsletters and also praised them as being helpful sources of information.

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[4] The Department of Health continues to provide overall AIDS public awareness. Regional Health Boards are responsible for day-to-day delivery of services.

The educational materials developed by the AIDS staff reportedly have received recognition in southern Canada for their concept. The pamphlets for the door-to-door campaign in particular have been popular elsewhere, with representatives from all over the world asking for copies.

Translation of Materials

There were some difficulties with translations of the materials. Inuktitut speaking informants complained that there were problems with some of the finals and grammar. There were also complaints that informal terms for the body were offensive to some who prefer the more formal terms which the language provides. There were some difficulties with the process of translation of some of the materials. The contract for producing radio ads was given to the Inuit Broadcasting Corporation, who were unable to complete their contract. Consequently, in order to ensure a timely completion of the planned TV spots, the AIDS Project had to take over the project.

The original scripts for 10 different spots had been written in English by a Francophone, then translated into 10 native languages. In order to ensure that what was said was accurate, the AIDS staff worked with the Language Bureau of the Department of Culture and Communications to review the nuances and message of every word and every frame. For example, one message was that "if you sleep with someone you will get AIDS". It was concluded that this could mean that if a person slept beside another in a tent even without intimate contact that AIDS was the likely result. In all, 75% of the spots had to be re-recorded. CBC were very helpful, according to AIDS staff, contributing the use of their studios for the two months required to salvage the project.

TRAINING

Between 1987 and 1990, workshops were held in 35 different communities. Five of these communities enjoyed visits on two separate occasions, Hay River three, and many different educational sessions were offered to various groups in Yellowknife. Most of these workshops welcomed whoever showed up, although some were meant specifically for particular groups of participants, such as correctional centre inmates, teachers, or Arctic College students.

Unfortunately, due to staff turnover among professional populations, few nurses or other caregivers we interviewed have attended any of these sessions. We interviewed few of the general public, but we encountered no one who recalled any such seminars in their communities. Only six of the people we interviewed in 13 communities had attended an AIDS training seminar in the NWT.

Only one of these is a nurse, a long time Yellowknifer, who complained that the content of the workshop provided to the Stanton Hospital staff was primarily epidemiology, which was not what was required at the time. We met only two nurses who had any specific AIDS training or experience from elsewhere. A few had attended brief information sessions at the Northwest Territories Registered Nurse's conference and one had attended the Vancouver AIDS conference. Most nurses interviewed received their information from professional journals or from southern sources.

Another individual we encountered is a social worker who attended a seminar in 1987, but was unsure who had sponsored it. His description of the event was that people were uncomfortable. The other four informants were Community Health Representatives, who recalled attending a workshop "quite a while ago". (The lack of follow-up, however, has dimmed their recollection of the workshop to the point of ineffectiveness.) The turnover among nursing staff means there is frequently no experience or knowledge base to share at a professional level. This was identified as a problem by at least two of the CHR's.

Nurses were the most vocal in pointing out the urgency of their need for training and their frustration that none seemed to be available to them. Topics mentioned for nursing staff were testing, the nature of the disease, counselling, and treatment possibilities.

There were many calls for training for the local caregivers who will be on the front line. Several expressed some hesitancy to engage in any AIDS education or counselling activities without some specific preparation. When asked what structures were in place to keep themselves up to date about AIDS, most said "none" or "my own initiative". Professional newsletters were next in line. Only 3 people responded that they used training provided by the Department of Health to update their knowledge.

One of the former AIDS Project staff described training sessions as being unplanned, with their focus being an attempt to meet the specific needs of whoever showed up, rather than on a set curriculum of study.

Community Workshops

The AIDS Project files contain some data regarding community and professional training workshops which were offered over the course of the project. **(See pages 15-16, "Community Presentations and Workshops".)** Participant evaluations of training sessions conducted during 1990 indicate that in general, participants were satisfied with what they received. Similar evaluations from other years were unavailable.

There were no important differences in the patterns of the responses from various groups of participants, except for their responses to the length of the workshops: adults were more likely to say they wanted more time, teens were more likely to say the workshops were a little long, but the numbers of people making either statement were few, with most people indicating that they were satisfied with the length of the workshop.

There was overwhelming agreement with these thoughts:

- that the workshop presentation was relaxed, informal, and straightforward, making it easy to talk openly
- that the workshop was interesting and informative
- that participants learned something they didn't know before

There was very strong support for:

- the resource materials
- the knowledge level of the instructors

The responses to several rating scales were documented:

"HOW EFFECTIVE WAS THIS WORKSHOP IN HELPING YOU TO UNDERSTAND WHAT CAUSES HIV/AIDS?"

Excellent	50%
Very Good	34%
Not Sure	14%
Poor	4%
Very Poor	3%

"HOW EFFECTIVE WAS THIS WORKSHOP IN PROVIDING YOU WITH INFORMATION ABOUT WAYS TO STOP SPREAD HIV AND HOW TO PROTECT YOURSELF FROM HIV INFECTION?"

Excellent	54%
Very Good	24%
Not Sure	8%
Poor	2%
Very Poor	3%

"HOW WELL DID THIS WORKSHOP ANSWER YOUR OWN QUESTIONS AND CONCERNS ABOUT HIV INFECTION/AIDS?"

Excellent	43%
Very Good	33%
Not Sure	11%
Poor	4%
Very Poor	5%

The most common recommendations were these:

- have a real person with AIDS speak to the class
- make it longer (adults)
- make it shorter (teens)

In Fort Smith, Uncle Gabe's Friendship Centre attempted to organize a community workshop on AIDS which was advertised heavily, with personal invitations to community leaders. One native leader refused to attend stating, "This is not one of our priorities. This is not our problem. When one of our people gets it and dies from it then it will be our problem." As a result no native leaders attended this workshop. In fact no one other than a few community professionals and caregivers attended.

There have been some initiatives in training that have originated from outside the government. The Anglican Church has taken initiative to ensure that its clergy are well-informed. At Arctic College, Thebacha Campus, a Master's student prepared and piloted an AIDS education package for students. In the Keewatin there were reports of private individuals conducting private sessions in the name of education which were in fact labelled as excuses to promulgate prejudice against gays and whites and were not welcomed by the communities they were offered to.

PROJECT FUNDING, ORGANIZATION AND STRUCTURE

From the outset of the activity funds have been made available from the Government of the Northwest Territories budget and a National Health Research and Development Grant from the Federal Government. Separate funding was made available for the door-to- door campaign which had as an objective the distribution of AIDS (and other health information) to every household in the N.W.T.

Initially, AIDS education was the responsibility of the federal government's Health Services. The Family Life Education Program, (which was first created under a special grant from NHRDP to specialize in spousal assault training) delivered most AIDS education, along with their other duties in sexuality education. Their positions were adopted by the Territorial Government when the transfer of responsibilities occurred from the federal government to the Government of the Northwest Territories. They were then pressed into service for six months solely to provide AIDS education while the AIDS Project got off the ground. Afterwards, they continued to offer some AIDS education along with their other training to complement the work of the AIDS Project.

The AIDS Project (with some reporting and structural confusion in the early stages) has been a functioning section of the department of Health. The Project in its final stages reported to the Head of Health Promotion/Education. Recently, the Project came to a conclusion. Future plans are to employ one person as a Health Promotion Officer whose prime area of responsibility will be AIDS education, and who will act as a consultant to regional Health Promotion Officers employed by the Regional Boards of Health. At present, these positions are not in place and no formal AIDS education structure exists.[5]

The strengths of the Project organization and management which were most frequently mentioned were the dedication and professionalism of individual staff members. Good team work was mentioned, as was the degree of political support from the Executive of the Government of the NWT, which supported the risk of some frank ads and materials to further the AIDS message.

The weaknesses centred primarily around three issues: funding, relationships between the Medical Directorate and the Health Promotion divisions, and inconsistent leadership.

Staff mentioned that they never knew for sure whether or not there would be money in the budget available for the projects they wanted to initiate. One week they would be told that money was tight and no development could proceed, then shortly after they would be advised that in fact there was too much money in the account which had to be spent before the end of the fiscal year. There were apparently four such "flipflops", as one former staff described them, which left the entire team demoralized. When the federal Minister of Health, Peron Beatty, announced that no further funds would be available to the Project, staff motivation took a serious turn for the worst. According to several, the Project died at that point, even though there were still several months in its intended lifespan.

The relationship between the Medical Directorate and the Project staff appears to have its roots in unclear job descriptions and reporting relationships, due to early overlaps in duties at the time of transfer. There are reports of rivalries between staff and conflicts regarding to whom certain positions should report. One of the bones of contention seems to have been who should take responsibility for professional development for nursing staff. Even after four years of operation of the AIDS Project, this issue is still one of contention, as indicated by a recent controversy over updating nurses.

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[5] In 1992, four Regional Health Boards were allocated Health Promotion Officer positions, bringing the current total in the NWT to five.

Another issue was the style in which decisions were made. Several staff related their frustration at having the Medical Directorate impose protocols. Personality conflicts and personal rivalries appear also to have a bearing on this struggling relationship.

There were complaints from all of the former AIDS Project staff interviewed about the inconsistency of leadership provided to the Project. Some spoke of poor hiring choices and of expecting more from the co-ordinators who were selected. Others described in detail the leadership inadequacies of some of the co-ordinators. All mentioned the frustration of having frequent turnover and gaps with no leadership at all, or interim acting co-ordinators who were not consistently dedicated to the AIDS Project, with their own priorities to be concerned about. The Project saw 6 co-ordinators or acting co-ordinators within a year. There was a six-month period with no one at the helm at all. There was deep bitterness from a number of former staff about the emptiness of working so hard, so professionally, and seeing their efforts, in their terms, wasted, due to lack of leadership when it was most needed to fight for funding continuity.

Almost everyone pointed towards to the tumultuous climate of the transfer of responsibilities for health care from the Federal Government to the Territorial Government as being the primary source of their woes. Such a great deal of time and worry and priority and money was spent on trying to make the transfer smoothly, that, as one person phrased it, "I guess we just fell through the cracks".

This lack of consistent leadership appears to have resulted in a lack of long range planning, poor staff relations and morale problems. One former staff member commented that the AIDS Project dried up after the first flush of excitement after the first ads, and that the momentum of the Project could not be sustained in the context of the Government and its built-in problems.

Several people remarked that either there were no clearly defined objectives or that if any existed, they certainly were not clear to them. There were no measurable performance standards, no built-in evaluation plans, no planned follow-up for activities to assess their immediate impact.

Mentioned also were inconsistent guidelines from senior management, inappropriate job descriptions, and unclear roles and responsibilities for the advisory committee.

Another common complaint was the frustration of working within the government bureaucracy and getting bogged down in "red tape". Even outside contractors complained of the inability of the Department of Health to stick to its own scheduling, its lack of follow-through on important decisions and actions, and its failure to respond to private initiatives.

Agencies Providing HIV Information

In the communities, the agencies most frequently listed as providing AIDS education are nursing stations, public health offices, and CHR's (87%). Also mentioned were Social Services, adult education centre, friendship centres and drug and alcohol centres, although these apparently do far less AIDS education work (24%).

About 14% of community respondents were aware of the AIDS Project and all of these described their relationship as "consultative, co-operative or a close partnership". Most medical personnel had heard of the AIDS Project, however many other caregivers are not aware of its existence. Even people with at least five years service in their communities are not aware that an AIDS staff exists to serve them. Even among some who knew of the AIDS Project, there had been no contact with them at any time. Where there had been some contact with the AIDS Project, it was usually in order to receive educational materials.

When asked, "How could the Department of Health AIDS Project change to help you more?", the most frequent responses were:

- don't know (26%)
- changes to educational materials (19%)
- changes to training (12%)
- changes to consultative services (9%)
- more frequent contact (9%)

When asked "How would you rate the organization of AIDS education services in your community as it is now?", 62% of respondents said "Unacceptable" or "Poor", usually because there was little occurring at all.

The most common responses to the question "What should be the future of AIDS education in the next few years?" mentioned new initiatives and new strategies (47%). While most could not describe exactly what the administrative should look like, some expected roles were clear. Strategies that should originate from Yellowknife headquarters were materials distribution (44%), materials development (60%) and training (58%). Initiatives such as informal counselling were clearly seen to be the responsibility of the local communities (55%). Most agencies had no specific goals planned regarding AIDS services and the only type of assistance requested from the GNWT was increased funding. Most did not know where to start or what to ask for (85%). Nurses, clergy and adult educators were most likely to mention training as a desired responsibility for the Department of Health.

Policy Development

AIDS staff spoke of their role in drafting or assisting with the formulation of the Department of Personnel's policy for employees who are diagnosed as being HIV+ and the Medical Directorate's policy regarding testing and treatment.

However, without exception there was no one at either the Regional or community level who had any idea of any policy development. There were requests, some urgent, for policy development help. School principals wanted to know what the Department of Education was doing about developing a policy for the schools when they are confronted with the first child with AIDS. College staff wondered what would happen when one of their students was diagnosed. Many professional caregivers interviewed asked about the GNWT's policy regarding staff members with AIDS.

CHAPTER 5

EVALUATION RESULTS

SUMMARY OF STRENGTHS AND WEAKNESSES IDENTIFIED

This section highlights the most prominent strengths and weaknesses which are apparent in the AIDS Project and its results.

Strengths

1. AIDS has entered the vocabulary of the people of the Northwest Territories. There is an Inuktitut version of the word "AIDS".

2. About 70% of people interviewed could recall seeing something relating to AIDS in some medium.

3. People are more likely to talk about AIDS openly and to discuss its implications for their personal lives.

4. Several local initiatives to educate and to prevent AIDS infections have been implemented throughout the Northwest Territories, most of these completely designed and delivered by local people.

5. Some of the educational materials, notably the newspaper ads and the pamphlets prepared for the door-to-door campaign received high ratings for their content and boldness.

6. Some of the materials have received international acclaim for their approach and native language format.

7. Special resource materials, the school health curriculum and the counselling protocols manual for nurses have been well received by those who have used them.

8. The dedication and professionalism of individual staff members was frequently praised.

Weaknesses

1. There is no indication of significant sexual behaviour change among the people of the Northwest Territories. In fact, there is widespread belief among caregivers and informed respondents that prevalent sexual practices put much of the population at risk for AIDS infection.

2. There is widespread denial of personal or community risk from AIDS infection among the general population.

3. The removal of the AIDS education campaign from the public eye has created a widespread misconception among the general population that the AIDS scare is over and there is no more need for concern.

4. 95% of respondents think that printed pamphlets are ineffective. Most printed material is not read at all, in any language. There are some difficulties with translations reported.

5. The training and delivery methods used for the door-to-door campaign were inappropriate and ineffective. Many people did not even read the information left on their door steps.

6. It is reported that only 40% of schools teach the AIDS portion of the school health curriculum.

7. The approach by which educational materials were scheduled for public consumption received poor ratings both from former AIDS staff and from marketing experts.

8. Many people are unaware of the existence of the HOTLINE.

9. Although several training workshops were provided for both professional caregivers and the general public, few professional workers now in the communities have ever attended an AIDS seminar, due to the high turnover among caregivers, especially nurses.

10. Most caregivers, other than medical personnel, are unaware of the existence of the AIDS Project and of what it could offer to assist with their community work. Frequent turnover of caregiving staff has created a cadre of newcomers to the north, most of whom have not been exposed to the AIDS educational campaign run in the earlier stages of the AIDS Project and have limited experience or knowledge about AIDS from elsewhere.

11. Inconsistent leadership, staff turnover and inconsistent guidelines from senior staff were cited by many as the main barriers to effectiveness of the AIDS Project. Many examples of mismanagement of the AIDS Project were described by all former staff other than senior management.

12. The relationship between the Medical Directorate and the Health Promotion section was one of conflicting roles, responsibilities and reporting relationships which still causes stress and interferes with the performance of job duties now for some staff.

13. Most Regional Health Boards are not yet prepared to assume an important role in AIDS education as planned by the Department of Health, and require assistance in the form of funding and person years, suitable educational materials, program guidelines and policies.

INTERPRETATION OF FINDINGS

Positive results

One of the most significant results of the AIDS Project, as well as information from other sources which has reached the communities, is that the word AIDS is now known throughout the Northwest Territories. In spite of some uncertainty about how the HIV virus works and is spread, and in spite of denial about personal risk, most people in the North at least know that AIDS exists and is dangerous. We have no way of knowing how much of the credit is due to the AIDS Project and how much to other outside sources. However, the fact that AIDS has entered the vocabulary of the north is an important observation.

There are other benefits which are perhaps more tangible. The AIDS campaign gave impetus to the development of other important programs. One of the most notable is the development of an AIDS unit in the School Health Curriculum. This led to an initiative from Arctic College's Teacher Education Program, which developed a special unit to prepare teachers to deliver the health curriculum with emphasis on AIDS. The unit has proven to be very successful, preparing northern teachers to handle the subject area more confidently than their southern trained counterparts.

The AIDS Project can also be credited indirectly with the development of some community education initiatives. For example, Uncle Gabe's Friendship Centre in Fort Smith and the Ingamo Hall Program in Inuvik both have developed and delivered workshops designed to help community people, particularly those caught in substance abuse, become aware of the threat posed by the HIV virus and how to guard against it.

The educational materials developed by the AIDS Project must also be credited, in spite of some problems, with their innovative approach and technical quality. The experience of the AIDS staff in producing 10 different TV ads in 10 different languages was a considerable undertaking. This was likely the first time that such a feat was attempted in the Northwest Territories for any purpose. The production of the many radio, TV and print materials in so many languages, with specific content and custom-made format was a sizable task. We have been unable, through our contacts with the World Health Organization, to locate anything else on the same scale relating to AIDS education.

It is important to remember that the Department of Health was pioneering with its AIDS Project. There was no model to guide its development or activities. Decisions often had to be made on the basis of educated guesses in a very demanding environment. There were some problems with leadership and with strategies, but this is to be expected in a fledgling program. The AIDS Project staff are to be commended for their courage and determination to initiate and complete innovative and formidable tasks.

Negative results

There are three crucial areas of weakness in the Project to date. The first is that the AIDS Project has failed to impress upon the majority of the native population any urgency to change their lifestyles in the face of the disease. The high profile and unique advertising has failed to bring home to the population that HIV/AIDS is a northern and native problem, and not just a southern white man's problem. This impression tends to be reinforced by the fact that the only AIDS advertising appearing on television now is from American stations such as Detroit. Most of these ads feature white or black victims, often gay men. This observation adds to the idea that AIDS has nothing to do with the north.

It does appear that purchase of condoms and pick up from free supplies has increased overall. However, we have no information as a result of this study about whether or not condoms are actually being used for sexual activity or how often. A recent study in Vancouver indicated that while free condoms are being snapped up quickly and sales from vending machines are up, the actual use of condoms is only very minimally increased. Certainly the STD rates in the Northwest Territories suggest that condom use does not occur as regularly as it might.

The second critical weakness is that the decline of information to the public after late 1988 has been seen as a statement that there is nothing to worry about. "If the government isn't worried any more, then there is no reason for me to be concerned" seems to be the prevailing attitude.

The third critical weakness is that the Project has failed to rally local support by fostering community team work with other concerned agencies. It was clear from the community interviews that alcohol and drug workers, social workers, clergy and adult educators all saw a place for themselves in combating the spread of HIV/AIDS. They are not aware they were welcome on the team, however, as none had ever been contacted by the AIDS Project.

Defining the Problem

In considering where to go from here, we are faced with two dilemmas: First, can AIDS really be a plague even worse than the great epidemics of a century ago? And then, if we answer yes, how can we successfully deal with it?

If the warnings prove to be exaggerated, and the toll of AIDS among those at risk who ignore the warnings is less than or comparable to the toll of alcoholic violence or suicide, then unleashing extraordinary efforts will be seen as a massive misallocation of vital resources at a crucial time. If, however, as a result of all our studies, we are convinced that the threat is real, then we have the duty to urge that this issue becomes the most urgent one facing the government. All other vital causes move back a step or two in priority: questions of economic development and cultural regeneration fall behind the basic concern for survival.

Our assumption now is that the warnings are well founded, and that there is indeed an urgent need for emergency action. That action should be swift and decisive. The fear that information may cause panic or prejudiced behaviour toward suspected infected persons may be real. But the alternative is for people to continue to believe this disease has nothing to do with them, which is equally, if not more, destructive.

The action campaign should target what the knowledgeable people surveyed state to be the prime focus of danger: casual unthinking sex while drunk. Many of these knowledgeable people go on to state or to suggest that the underlying cause for concern is not so much sexual mores but alcohol abuse. They infer that if the alcohol problem was solved, the AIDS problem would be no more threatening than it is in the south: a grave danger, but not one that will leave settlements as depopulated as African villages have been.

However, in twenty or more years of continuous well-funded effort we have failed to eradicate the alcohol problem. At that rate, there is no point in increasing our efforts in this arena alone: the AIDS problem will be upon us before any results can be seen. So we must focus on the key point only, the intersection of alcohol and drugs with sex. This leads us to the second dilemma.

As soon as we start to deal with the world as it really is, we begin to lose some of our support. Many decent responsible people may be shocked to the point of anger when sensitive topics or certain sexual practices are mentioned in print or on the air. Several of the key people interviewed mentioned the hesitancy of the Department of Health and of media outlets in permitting the publication of realistic material. However, several others among those surveyed are obviously opposed to such frank material. If we were to raise this topic among a group of concerned and informed northerners it is obvious a very lively debate would result.

The first waves of AIDS messages had as their objective the education of northerners to the existence and the dangers of AIDS. It is time now for "the second wave" whose objective will be behaviour change. Decisions about how to conceive the needed behaviour-changing AIDS campaign will need to focus on three aspects of programming: the approach, organizational structure and leadership, and the media used for the campaign.

APPROACH

Our suggestion is to make continuous debate the first part of the campaign. The Government Leader and the Minister of Health should promote serious discussion of this topic in the Legislative Assembly. The media should give full coverage, and should go further by providing forums for discussion of the topic: "Is AIDS such an immediate threat to the very survival of northerners that it demands an explicit program of education?"

From a long-term point of view, the critical issue will be assisting individual northerners to re-examine their lifestyles and make conscious choices as to what they want life to be like. Many people recommended that this be done from a perspective of values and spirituality, personal and community empowerment, and the development of whole healthy individuals, families and communities. HIV/AIDS cannot be dealt with like some isolated disease that strikes regardless of what an individual does or how he or she lives. AIDS is a lifestyle issue.

This of course is a challenging task because the extent of cultural and social breakdown and its accompanying layer of personal self-destructive behaviours is quite deep. The attitude reflected to us by many people was "The idea of me having any control over my life is ridiculous. Why should I worry about a disease there's no cure for? Tomorrow will look after itself, and if it doesn't, well, I could not have changed that anyway."

Another very difficult area is the lack of professional training of local caregivers, particularly nurses, in the care and counselling of HIV/AIDS infected persons and their families. This problem is related to the heavy turnover of professional staff. However, even more permanent resource persons such as the Community Health Representatives have had insufficient specific training that will prepare them for their coming role.

The importance of immediate training for medical staff cannot be underplayed. Nurses and CHR's were the number one choice of most informants for referrals pertaining to AIDS, and yet they are the most vocal in calling for training for themselves as well as other caregivers. It is significant that during the past year, nurses looking for basic information about AIDS and how to deal with it have constituted the largest number of callers to the HOTLINE.

Governmental responsibility

The task ahead for government is to somehow develop programs which will be effective, and this is not an easy burden. One of the difficulties for caring individuals working within the government bureaucracy is the built-in institutionalized resistance to changes which will "rock the boat".

Part of the difficulty is that AIDS in itself is not the real issue. Social problems would still exist in the communities even if AIDS had never surfaced. AIDS has become more of a focus now because it is a complicating factor: people will die sooner as a result of their social behaviours. When looked at in this light, any AIDS campaign focused on encouraging personal self-control in order to protect oneself is likely not going to be successful.

The pivotal point which will need immediate attention is the intersection between sex and alcohol. However, the long-term solution to AIDS appears to lie in the treatment of the whole person. All of the issues are tied together and need to be considered together. Our belief is that as these problems are dealt with, the fractures in society that put people at greatest risk from HIV/AIDS will begin to heal and the risky activities will decrease.

It is extremely difficult, however, for government to think this way. Government is in the habit of thinking politically. Damage control is, out of practicality, the prime concern: what fallout will result if we acknowledge this problem? This has lead to an institutionalized denial of the extent and depth and impact of social troubles which are assumed as an everyday reality by those living in their midst. We submit however, that the politics of survival must be different from the politics of power, which usually has damage control as its focus. Our most important recommendation is that the AIDS Project not be dismantled but should be expanded and the focus changed.

Subsequent strategies

After public debate in the legislature has opened up the topic of AIDS for active and widespread discussion, the first strategy in the new AIDS campaign needs to be for the Department of Health to act as a catalyst to bring together all of the various agencies, groups and individuals who are able to help in the communities. This should begin with concerted lobbying with the leadership of all departments to establish the commitment to a working partnership using all of the resources which each can bring to bear.

A NWT-wide conference should be organized immediately whose main objectives will be to reactivate the image of AIDS as a current risk to the people of the Northwest Territories, and to find ways to develop a structure that will allow blurred organizational boundaries, shared responsibilities and joint action against all of the lifestyle issues which affect AIDS. A task force should be established from this conference to advise and oversee the further development and implementation of strategies arising from the conference.

The Department of Health then needs to take a proactive role in ensuring that each Regional Health Board has the resources available to conduct AIDS programming at a local level. This will likely involve locating funding and person years for a Health Promotion Officer, whose main responsibility will be AIDS education, in each region. The Department of Health will need to supply the regional boards with guidelines for developing their own local programs.

In the meantime, The Department of Health needs to continue providing training to local caregivers who can take leadership in their own communities. The Family Life Education Program (FLEP) has been using a program called "Working Together for Change" which uses a technique called "Popular" Education, one we think provides an excellent model for ongoing training. Based on the work of Brazilian educator Paulo Friere, the FLEP program assumes that people who are confident and assertive can be a powerful vehicle for social change, without possessing professional skills or job experience. The program teaches people how to be facilitators and to initiate learning and action, and should be expanded as a primary vehicle for assisting caregivers to take leadership in preparing for the arrival of AIDS in their communities.

Simultaneously, the AIDS Project should continue to deliver AIDS information workshops to professional caregivers, especially nurses and CHR's. The focus needs to be those issues of most concern to those who will be on the front lines: counselling, treatment and care of patients and families, testing, and the impact of the AIDS virus on victims. Due to the high turnover rate among community health professionals, there should be at least two AIDS information workshops for professional caregivers in each region each year.

The AIDS Project needs also to lobby with other government departments and to assist them in developing programs which can contribute to the long-term healing required to prevent AIDS. For example, it is clear from the comments of many contributors that sexual abuse is a major issue. It is reasonable to assume that before we will see any significant increase in the practice of "responsible" sexual behaviour that we will need to ensure proper treatment for sexual abuse victims and abusers. The treatment of alcohol abuse is also a critical area. Programs to combat suicide and family violence are important as well.

All of these social problems are symptoms that cover much deeper concerns, and somehow all need to be tackled. Because each of these factors may affect AIDS and its prevention or spread, they too have become the responsibility of the Department of Health now.

In addition to a need for therapy, education about the body is a primary need. People who have little or no basic knowledge would not be able to understand crucial information, such as the fact that receptor cells for the virus are located only in the vagina, penis and anus, thus almost eliminating danger from casual contact. Although many people said they have knowledge of AIDS, it is abundantly clear that those who say they would shun or even express fear and hostility in a violent manner toward an HIV+ person have no true understanding of the disease.

This type of awareness education needs to be included not only as part of school health and adult education programs, but anywhere helpers can fit it in: friendship centres, drug and alcohol treatment programs, and public health home visits. To facilitate this, the next area of activity should be the development of learning materials in audio-visual format to be distributed to each region for their use in local education initiatives.

Throughout all of these activities, evaluation should be "built-in" by beginning with the development of measurable performance standards, strategies for assessment and time deadlines for goal achievement. Evaluation should take place in two ways: ongoing program monitoring according to predetermined standards and format, and outside independent evaluation annually.

ORGANIZATIONAL STRUCTURE

The government is in the habit of thinking "territorially", in the sense that the Health Department doesn't deal directly with education, Social Services doesn't deal with economic development, and Corrections doesn't deal with health promotion, and so on. But it has become necessary to force a blending or blurring of boundaries between Departments. All Departments must be prepared to work together on all issues at once at a headquarters level in order to ensure that teamwork happens at the local community level.

The caregivers in the communities must work together, each providing their own brand of care, so that AIDS is not seen as just a health issue. It is also an alcohol issue, a spiritual issue, a literacy issue, a community development issue, an economic issue, and a political issue. Any group organized to act on behalf of the community to bring about positive change in people's lives must become part of the solution for change. The key players at the community level, in addition to nurses and CHR's, will be teachers and adult educators, drug and alcohol counsellors, social service workers, clergy, elders and community councils.

The Department of Economic Development has a part to play in developing employment opportunities for northern residents. One of the root causes of dysfunctionalism, or lack of ability to function properly, is lack of purpose. Purpose must be taken on by the people. One of the best approaches is through programs that allow people to become independent, as were their parents and grandparents. The Federal Department of Employment and Immigration, Canada Employment, through their training and Canada Job Strategies should also become involved in the co-ordinated effort.

We are aware that this concept will be difficult to put in place in a practical way. However, we are of the opinion that there is no time to waste, given what we now know about the lifestyles of the people of the Northwest Territories and the level of denial of personal risk from AIDS.

The Role of the Department of Health

With the passing of responsibility to the regions for delivery of the AIDS education program, we believe the headquarters function in Yellowknife must retain certain overall responsibilities. The focus now is no longer on education for information; now it is education for lifestyle change. This requires total effort.

It is critical that efforts to achieve agreed-on Territorial goals be co-ordinated. It does not make sense, given the mobility of the N.W.T. population, for this program to have varying goals unless it can be clearly shown that needs and circumstances are unique to a region.

Yellowknife headquarters must also retain overall responsibility to ensure programs are carried out and objectives met. This is not an easy task, which makes it a candidate for inaction. With the current rate of regional staff turnover, the AIDS Project may fall between the cracks as something to be done another day. There will have to be ongoing policy and continued program supervision and support.

It must be recognized the time is past for the Project to solely concentrate on the spread of information. Most people at least know what AIDS is. Some have a good grasp of what is involved, while others' grasp is vague. The problem now is to translate whatever information is out there into active changes in lifestyle.

The ongoing task cannot be done by an isolated Department of Health. This is not solely a health problem. In blunt terms, this is a survival problem. It is the responsibility of every department of government and of every individual in every community. Health care people cannot carry this load alone. This is a burden for everyone, for survival is everyone's business.

It is our opinion that the Department of Health, which has pioneered in the delivery of AIDS programming in the NWT, should continue to take a leadership role. The Department of Health staff are the ones who initiate action but the load is to be shared by all who care for the survival of the people and the communities. While the activities at a local and regional level will be of prime importance, local people cannot be expected to shoulder complete responsibility on their own.

Our recommendations, therefore, are based on government departmental cooperation, as well as the involvement of all community agencies and community action. The first set of recommendations are of concern to the headquarters group. The second is directed at regional bodies, such as Regional Health Boards and other local interest groups.

The recommendations directed to the Department of Health are done so with full awareness that the Department is only the catalyst. There are places where the Department of Health does indeed take the lead but there are also places where the Department will give over leadership to others.

From the outset it should be accepted that there will be no reduction in costs. In fact, the costs of attempting to bring about lifestyle changes may be extremely high. It will take effort and money. It may require the combination of many portions of many budgets. What is required is a total approach to help communities and their populations out of the dysfunctional mode in which many are now locked.

In determining budget development the debate must conclude that if AIDS becomes a widespread epidemic (as many health care professionals in the communities and regions believe it will) the resources consumed simply caring for patients will require all the money available. The question is not how much to spend but whether to spend it attempting to take a "wellness-centred" action as opposed to simply dealing with an after the fact "sickness-centred" action. The latter approach cannot be repeated too often.

Building a whole new way of communicating difficult material to a population unprepared to receive either the information or the implications it holds for lifestyle changes was, and still remains, a major challenge.

Problems frequently identified by former AIDS staff are lack of leadership, disorganization, mismanagement, staff turnover, conflicting reporting relationships and funding uncertainty. Fortunately, these are problems which can be changed. With the right leadership and organizational structure, a future AIDS Project could be highly successful.

It would seem from the survey that some people at least believe the government actions to date have been poorly thought out, scattered, erratic and inefficient. That would suggest that we need:

- commitment to the project, translated into the willingness to give the team exceptional powers.
- a team leader who is inspirational, magnetic, a good team builder, and able to see long-term projects through to their difficult goals.
- staff who are neither short-term northerners nor the temporary casual employees often used in a short-term project. We suggest that the departments be searched to find officers who combine efficiency with the more human qualities needed for this project.

Model for Future Development

We are recommending a model in which there are at least three roles to be played:

1. Regional Offices of each government department and other community agencies will provide the power and action to carry out activities which address the lifestyle problems of their communities in their own way.

   The primary role of local agencies and government departments will continue to be service to the public.

2. The Regional Health Boards will work closely with the various government departments and with other private agencies in the community, such as friendship centres, women's centres, crisis centres, mental health groups and so on.

   The role of the Regional Health Boards would be primarily one of local co-ordination of various types of AIDS-related activities.

3. The Department of Health headquarters in Yellowknife will take primary leadership in the development of AIDS-related programs, materials, policies and guidelines which the Regional Health Boards and other government departments can then use as the foundation of their community activities.

   The nature of the role of the Department of Health would be to act as a catalyst and as leader in the development of appropriate AIDS education services.

MEDIA

Personal contact with northerners who have the HIV virus and are willing to share their experiences and knowledge and support with other northerners is a potential resource. An effort should be made to contact all those diagnosed as HIV+ and encourage their assistance through speaking engagements. A list of protocols should be developed to guide such approaches to victims. The Government of the Northwest Territories should be proactive in arranging for and funding speaking tours in northern communities.

The second line of attack is radio, because it is oral, it is cheap, and because almost everyone in communities listens to local radio. Radio ads should be continually updated and changed to maintain attention. More radio dramas should be developed in English and in selected native languages.

Some ads and drama should focus on breaking the link between alcohol and sex. These should be bold, frank and honest, and should show life as it really is. Humour can be a useful medium. Others should focus on positive lifestyle examination and long-term personal growth.

TV and video are the next lines of attack, because they are oral and visual, and because TV's and VHS machines are found in almost all northern homes. The focus should be on animated humour for short ads, and on community and personal development for longer programs. Program leaders should lobby for the development of an AIDS segment in the new NTV programming. These TV dramas could be a visualization of those already heard on radio.

The Department of Health, in conjunction with the Department of Culture and Communications, should establish a media centre in Yellowknife whose responsibility will be to produce made-in-the-north audio-visual materials which can be used by community groups. The Department of Health should request that the Department of Culture and Communications take active responsibility for negotiating and arranging for media distribution and airing of programming developed for the AIDS behaviour-changing campaign.

Posters should be developed using key frames from the TV dramas and animations. Content must be 90% visual, with each poster focusing on one key point only.

Community groups who wish to develop their own materials should be encouraged to conceive cartoon-style print materials with a minimum of words. These can be developed and reproduced cheaply, with tailor-made features such as local buildings and people included in the drawings for realism and "face validity".

Due to the transience of the NWT population in general and the turnover among community caregivers in particular, an immediate first step could be to simply repeat the newspaper, TV and radio ads which have not been aired for some time. This could be an effective and relatively inexpensive strategy while development of new materials is under way.

OTHER CONSIDERATIONS

Further Research

This study collected anecdotal information (oral comments) which gives indications regarding current and prevalent sexual practices of the people of the Northwest Territories. However, while useful for the purposes of suggesting future programming directions, anecdotal information does not carry the same weight as does data collected by careful research when it comes to making difficult decisions. It is our opinion that the Department of Health should conduct a comprehensive sexual practices survey to determine what long-term mores and values surround the practice of sex for guiding future education programming. The United Kingdom recently completed such a survey which may provide assistance in its development.

Treatment Facilities

Interview respondents made it clear that their communities are not prepared for the coming AIDS epidemic. In addition to gaps such as skills training for caregivers and access to appropriate educational materials, staff, facilities and programs to treat and care for AIDS patients are not yet in place. With housing almost at crisis proportions of its own, it is not reasonable to expect that families will be able to care for their ill at home. However, nursing stations are already heavily used for other basic programs. Thus it is important that the Department of Health lay firm plans now for primary treatment facilities and hospices. Existing programs such as homecare, as well as others sponsored by other departments, will likely need to be extended or expanded.

FUTURE DIRECTIONS

One of the most talked about issues was the future roles which should be played by local agencies and by the Government of the NWT. There was not complete agreement regarding how much responsibility each should take, but there was quite consistent support for the following directions:

The main thrust is that there needs to be an increased role for both the GNWT and for local caregiving agencies and regional health boards. The relationship consistently described can be characterized as a team approach to AIDS education. The following phrases were used to describe the suggested relationships:

- a team approach, with blurred boundaries between agencies and institutions
- a partnership between the Department of Health and the community
- a community-based storefront approach, with co-ordination from the GNWT
- community networking, with the GNWT as catalyst
- a focus on the existing agencies, such as Adult Education and the Drug and Alcohol Centres, with training and educational materials provided by the GNWT
- a coalition of parties
- a cohesive multi-agency effort

There was a strong call for the development of local resources, and one of the main needs identified was a strong presence to bring the local resources together and to co-ordinate them. The following responsibilities were suggested for the GNWT Department of Health in such a coalition:

- act as a catalyst for the local helpers, to encourage the local caregivers to take initiative
- provide better quality, more usable, more visible educational materials for the use of the local caregivers
- provide policies to guide local initiatives
- provide training for nurses and other caregivers on a frequent and continuous basis
- conduct more HIV testing, whether mandatory or voluntary
- conduct a sexual practices survey
- supply condoms
- lobby with other government departments for more PY's and more support for staff such as social workers, drug and alcohol workers

- provide more PY's for community homecare workers

- dedicate more money to planning, rather than just reacting to the AIDS epidemic

- provide for long-term care facilities through hospices or services such as homecare

Although there was a desire expressed to see the local communities and Regional Health Boards to take on more of the responsibility for AIDS education and other related AIDS services, there was also a recognition that in most cases they were not yet ready to do so.

One of the most frequently mentioned problems was the lack of money and PY's with which to tackle the job. Boards told us they needed direction from the Department of Health, perhaps in the form of guidelines and well-developed program strategies for their use locally. The turnover of nurses and caregivers results in a lack of consistent long-term leadership in the communities. The expertise is not always there, and where it is, it may not stay there for long.

The consensus is that there will be a time lag of between two to five years before most of the Regional Health Boards are ready to even consider taking on AIDS education successfully, and likely a much longer time before a coalition of local caregivers could take on such a role. The problem, of course, is that we do not have the luxury of that much time.

> "In theory it's great to have responsibility at the regional level but in reality, we can't work without more money and commitment on a territorial basis. Too much responsibility is dumped on the regional level. AIDS education needs to be seen as a priority on a territorial level, just as are alcohol and drug abuse. Nurses are really not prepared for their role and don't know what it is. It needs to be determined at an NWT level what our role should be with regards to AIDS. Someone needs to make us do AIDS education and make it possible for us to do it. The work load and our own lack of knowledge are a problem right now."

There are strong indications regarding the directions which educational materials and strategies should take in the future. These are the most frequently mentioned suggestions:

With regard to strategies:

- Educational strategies should focus on maintaining a regular, consistent flow of information. Calls have been made, loud and clear, for a persistent, "all-out onslaught", and an ongoing program.

- The local community caregivers need to be encouraged to take as much initiative as possible, with CHR's and drug and alcohol workers being in prime positions to take leadership, with consistent support.
- Strategies should target risk populations by age and by sex.
- Better use can be made of the clergy.
- Elders and other local language speakers should be active participants in local campaigns.

With regard to media:

- The use of videos which can be made easily available to the populations at most risk is seen as a primary tool.
- The use of local persons with AIDS, preferably not gay men, is likely to be the most important educational tool of all.
- Print materials should be used as little as possible. When print materials are used, they should be cartoon, comic book, or colouring book style.
- Materials need to be produced in local dialects, where native language fluency and literacy supports the need.

There were a number of useful suggestions regarding the content of educational materials:

- Focus on the development of self-esteem and personal growth.
- Give attention to the emotional side of sex, not just the physical.
- Values, morals, and spirituality should be an important focus.
- Focus should be on positive messages, such as love, caring, and commitment.
- Help people to distinguish between those who are at risk and those who are not.
- Use the distinction between fear and being afraid for positive momentum.
- Place AIDS education in the context of social change and other related social problems, such as alcohol and drug abuse, suicide, and sexual abuse.

- Place AIDS education in the context of cultural change, of social oppression and empowerment, of individuals and of communities.
- Place AIDS education in the context of sexuality in general, including basic information about the body and how it works, as well as birth control.
- Focus on the development of the entire person.
- Focus on healthy homes and lifeskills.
- Phrase messages in terms that elders can understand, for example, comparisons with the TB epidemic and the starvation of the 1950's.

Several informants referred to an urgent need for the Department of Health to provide NWT-wide leadership in the development of policies to assist employers and public institutions with the development of appropriate protocols with regard to employees, patients and clients with AIDS.

CHAPTER 6

DISCUSSION OF FINDINGS

SUMMARY OF CONCLUSIONS

This section lists the major conclusions drawn from the information collected. Conclusions are arranged by topic area.

Indirect Indicators of Behaviour Change

1. A recent study of STD rates is inconclusive.
2. STD rates appear to be high throughout the Northwest Territories with no sign of decrease in incidence. In many cases, the same patients return with fresh infections regularly, indicating little change in sexual behaviour.
3. High pregnancy rates for young women continue.
4. Condom sales and pick up of free condoms seems to have increased greatly in some places, slightly in others, and not at all in others.

Sexual Attitudes and Behaviours

5. There is widespread denial about the risks of AIDS and its presence in the Northwest Territories.
6. The lifestyle of most communities is described as dysfunctional, with social and sexual behaviours which would be labelled as "bizarre" in southern Canada being the norm in many communities in the Northwest Territories. Depression, suicidal behaviour, spousal assault, incest, child sexual abuse and rape are common.
7. Sexual activity is very closely related with substance abuse, particularly alcohol. 100% of respondents told us that sexual intercourse and alcohol go hand in hand.
8. There is a widespread lack of accurate information about how the body works.
9. There are some misconceptions about how AIDS is caught, who is at risk and who isn't.
10. Some young people may be starting to change their sexual behaviours by using condoms, but there are few reports of adults doing the same.

11. There is concern among community leaders and caregivers that inadequate infrastructure is in place to handle the coming epidemic. Housing and adequate treatment facilities were most frequently mentioned.

12. Some caregivers are frustrated by a lack of support from local community leaders who do not see AIDS as an issue of priority for their people.

Community Initiatives

13. Several local initiatives to educate and to prevent AIDS infections have been implemented throughout the NWT.

14. Most local initiatives have developed with no assistance from, and in some cases, without the support of the Department of Health.

15. Communities need support from the Department of Education in order to be more effective in their local initiatives. Development and delivery of educational materials and training for caregivers were frequently mentioned.

16. Nurses and people who have lived more than 5 years in their communities are the most likely to be concerned about the seriousness of the coming epidemic.

Educational Materials

17. Many people expressed concern that the AIDS Project seems to have been abandoned. Several informants thought that the AIDS worry was over, as they had heard nothing about it for so long.

18. There is misinformation about the relationship between the HIV virus and AIDS.

19. About 70% of people interviewed could recall seeing something relating to AIDS, but few could recall specific details.

20. 95% of respondents think that printed pamphlets are ineffective. Most printed material is not read at all, in any language.

21. Comic books with identifiably northern characters, such as "Super Shamoo", may attract some people's attention.

22. Videos were identified as being the most effective way to get the AIDS message across, especially if they are funny, in cartoon style, short, and free.

23. Personal contact with someone who has AIDS was cited as the most effective approach. Meeting or seeing a Baffin woman on TV was mentioned more often than anything else as being the catalyst that led to personal awareness of the real risks of AIDS.

24. The materials developed for the door-to-door campaign were praised as being bold and accessible. However, the techniques used to deliver the materials were rated as being inappropriate and ineffective by most respondents.

25. The poster "Stopping AIDS Is Up To You" is in obvious evidence in all but one community visited. Often it was the only AIDS information people knew of in the community.

26. The newspaper ads were praised for their explicitness, boldness, creativity, humour and appeal to the reader. Only half of the respondents recalled seeing them.

27. The radio ads, also little recalled by the public, were praised by radio broadcasters who aired them.

28. TV spots were remembered by half the respondents, but some of these originated in the United States.

29. "Charlie's Last Homecoming" was recalled by only one respondent.

30. The "burgundy binder" of protocols and guidelines for pre- and post-test counselling was praised by those nurses who had seen it, but few knew of its existence.

31. The AIDS portion of the school health curriculum is used by only 40% of teachers, but is supported by most parents where it is used.

32. Most former AIDS staff are unsatisfied with the way in which educational materials were scheduled for public consumption. An independent marketing specialist noted that market saturation and rotating of advertising should not be a concern when behaviour change of this type in such a unusual climate is required.

33. NWT AIDS educational materials have reportedly enjoyed a favourable reception internationally.

34. Difficulties in the process of translation led to some inappropriate and unwanted results.

HOTLINE

35. The HOTLINE was not heavily used. Many community respondents were unaware of its existence.

Training

36. Although several training workshops were provided for both professional caregivers and the general public, few professional workers now in the communities have ever attended an AIDS seminar, due to the high turnover among caregivers, especially nurses.

37. AIDS Project files contain participant reports from people who attended seminars and reported satisfaction with their content.

38. Nurses were the most vocal in expressing an immediate need for training for themselves and other caregivers. Nurses and CHR's are the top choices of all respondents when referring a client who wants to know more about AIDS.

Project Funding, Structure and Organization

39. The strengths of the AIDS Project most frequently mentioned were the dedication and professionalism of individual staff members.

40. Inconsistent funding was a morale problem for staff and curtailed the development of some initiatives.

41. The relationship between the Medical Directorate and the Health Promotion section was one of conflicting roles, responsibilities and reporting relationships, and still causes stress and interferes with the performance of job duties now for some staff.

42. Inconsistent leadership, staff turnover and inconsistent guidelines from senior staff were cited by many as the main barriers to effectiveness of the AIDS Project.

43. The transfer of health care responsibilities from the Federal Government to the Government of the Northwest Territories is pinpointed as the source of many woes by most former AIDS staff.

44. Many examples of mismanagement of the AIDS Project were described by all former staff other than senior management.

45. Most caregivers, other than medical personnel, were unaware of the existence of the AIDS Project.

46. Communities expect the Department of Health headquarters in Yellowknife to be responsible for developing and distributing educational materials and training community caregivers.

Policy Development

47. Community caregivers are requesting policies from the Department of Health for their employees, students, clients and patients.

Future Directions

48. There needs to be an increased role for both the GNWT and local caregiving agencies and regional health boards. A team approach to AIDS education is required.

49. A strong presence is required to help develop local resources. The Department of Health is called on to provide this co-ordination and to be a catalyst in community development.

50. Regional Boards of Health require funds, additional staffing and direction in order to carry out their role in AIDS education.

51. An all-out, consistent, persistent AIDS education program is called for.

52. AIDS education should target risk populations by age and sex.

53. Videos and personal contact should be the main media, rather than print media.

54. AIDS education needs to focus on the development of the entire person, with the development of self-esteem, values and spirituality as important components.

55. AIDS education needs to be placed in the context of social change and community empowerment.

CHAPTER 7

RECOMMENDATIONS

RECOMMENDATIONS FOR THE DEPARTMENT OF HEALTH

This section lists specific recommendations aimed at the Department of Health for the future AIDS behaviour-change campaign [6].

Regarding Policy

1. Promote discussion in the Legislative Assembly which will bring AIDS and the need for a new campaign to the forefront.
2. Lobby with senior representatives of each Department of the Northwest Territories to establish procedures to promote co-operation between departments at a local level to prevent AIDS and provide care for AIDS patients and their families.
3. Develop a policy immediately which clearly states the desire of the Government of the Northwest Territories to involve all community resources in the AIDS Project. The policy must indicate government support for nongovernmental agencies and individuals who wish to initiate an AIDS Project. The primary resources at a community level will be churches, drug and alcohol workers, social workers, and adult educators.
4. Develop a government-wide policy for presentation to the Executive and the Legislature to ensure all government departments are actively involved in the program to combat AIDS.
5. Continue to provide leadership to the government and its agencies in the development of in-house policies that detail the position the government or its agencies will take when an employee or client is infected.
6. Design an overall suggested policy or set of policies which can be used to assist private employers in developing their own strategies to deal with an infected employee.

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[6] These recommendations were formulated in 1991 by an independent consultant, and are currently being considered together with other Department of Health policies and initiatives.

Regarding Relationship to Regional Health Boards and Community Groups

7. Organize, host and chair a conference with representatives of the following:

   - each Regional Health Board
   - each government department's senior leadership and regional offices
   - major native organizations
   - other important interest groups such as Status of Women, Pauktuutit, Native Women's Association, and friendship centres
   - leadership of the Arctic Dioceses of the Anglican Church and the Roman Catholic Church
   - Canada Employment and Immigration
   - Arctic College
   - community caregivers
   - traditional Dene and Inuit healers
   - CHR's

   The main goals of the conference would be as follows:

   - reactivate the image of AIDS as a current risk to the people of the Northwest Territories
   - update recent developments regarding AIDS and the local epidemic
   - establish guidelines for policy development
   - establish priorities for program and materials development
   - develop a structure that will allow blurred boundaries, shared responsibilities, and joint action against all of the lifestyle issues which affect AIDS
   - share the results of those portions of this study which relate to the public
   - prepare NWT-wide strategies for action

8. From the delegates to this conference, select a task force which will advise on and oversee the further development and implementation of the strategies arising from the conference.

9. Develop a system to inform health care professionals in the regions of the existence of known cases of HIV in their region.

10. Secure the funding required to provide each Regional Health Board with a person year for a Health Promotion Officer whose main responsibility will be AIDS education.

11. Provide explicit training to regional health care staff about how to discharge the tasks delegated to regional responsibility.

12. Develop practical guidelines for AIDS Project development and implementation which can used by the Regional Health Boards to prepare their programs. Packages should include:

    - development models for designing policies for employers and agencies
    - suggested job descriptions for those involved with AIDS education
    - models for the content and format of any educational materials which are to be developed locally.
    - a copy of recommended videos and other resources
    - lists of resources which can be ordered, along with addresses and costs of each
    - a recommended model for small group learning, similar to that used by the Family Life Educators, "Working Together For Change"
    - recommended models for treatment and follow-up care for HIV infected persons and their families
    - recommended techniques and models for bringing community agencies, government departments and other local resources together in a joint working group to prevent the spread of AIDS and prepare for future counselling and treatment requirements
    - recommended sources of funding available to local organizations and copies of sample completed application forms as guides for fund raising

13. Develop a list of protocols to guide the recruitment and support of northerners diagnosed as HIV+ to act as speakers. Take a proactive role in arranging for and funding speaking tours.

14. Expand the role of the Family Life Educators with a focus on the "Working Together For Change" program. The goal should be to facilitate the delivery of ongoing workshops regularly in each region as a focal point for personal change and community development.

15. Maintain a regular AIDS information training schedule for local caregivers, including nurses and CHR's. The focus should be on counselling, treatment and care of patients and families, testing, and the impact of the AIDS virus on victims. There should be at least two training workshops for professional caregivers in each region each year.

16. Continue to provide leadership and continuity in the development of all learning materials, in particular video. Ensure that educational materials, whether developed by the Yellowknife AIDS Project or by regional resource persons, share the same focus to ensure accuracy and consistency of message.

Regarding The Structure of the AIDS Project

17. Assign to the AIDS Project exceptional powers and independence [7]. This may require its establishment as an arm's length body or use of some administrative technique to remove it from the usual chain of authority and decision-making accountability which impeded its operations in the past. Use the highest professional standards in the selection of staff.

18. Secure the required funding to establish a media centre in Yellowknife whose main task will be to produce appropriate learning materials which can then be used by local caregivers for their AIDS education activities. Focus will be on audio/video materials.

19. Locate the funding to establish regional HOTLINES. Provide training to local counsellors using a professionally developed counsellor training program. Move the present line to the Medical Directorate and make it a line dedicated to dealing with the specific queries of medical professionals.

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[7] Editor's note: This Project has been phased out.

Regarding AIDS Project Activities

20. Plan for evaluation while planning program delivery. Develop an evaluation strategy which includes:

    - measurable, attainable, challenging performance standards
    - strategies for collecting useful information on a regular basis
    - format for recording information consistently
    - structure for reporting information regularly
    - formal evaluation conducted annually by an outside agency

21. Consult with other departments of the Government of the Northwest Territories to learn what information their field workers can contribute to the development of AIDS programs and materials.

22. Assist other departments of the Government of the Northwest Territories to develop programs aimed at the long-term healing of social structure as a way to prevent the spread of AIDS.

23. Develop an animated video, cartoon style, of no more than 30 seconds in length which uses "Proud Pete" as its inspiration. The accent should be on humour, graphics with no verbal or written overlay, and brevity.

    Produce multiple copies of the video for use as a "trailer" along with commercial videos shown at community theatres, on TV and similar uses.

    Have copies of this and other appropriate videos available for free use from existing video outlets. Provide a copy in the packages made available to Regional Health Boards.

24. Produce a video using elders to discuss lifestyle issues, such as spirituality, values, choices, and personal and community growth. Present lifestyles of native persons who have a positive image as role models.

    Provide a copy in the packages made available to Regional Health Boards.

25. Update radio and TV ads regularly to maintain attention.

26. Assist the Department of Culture and Communications in negotiating with the most-watched TV stations received in the NWT to insert short AIDS clips into commercial programming.

27. Develop and produce new media messages:

   - produce new radio dramas in English and Inuktitut.
   - develop a new round of TV ads and dramas and other programming.
   - lobby for an NTV special on AIDS in the Northwest Territories.
   - develop new posters which are linked directly to the radio and TV ads.

28. Repeat newspaper, TV and radio ads which have not been aired for some time as an immediate strategy while new materials are being developed.

29. Assist the Departments of Social Services and Education in developing resources for their community workers to help people cope with and give up substance abuse.

30. Provide free condoms to more outlets, including businesses such as video rental counters, convenience stores, fast food restaurants, schools, adult education centres, counselling centres, friendship centres and any other organization which requests them. Encourage the display of condoms in easily accessible locations.

31. Conduct a comprehensive sexual practices survey, perhaps using the recent survey completed in Great Britain as a model. One of the goals of the study should be an examination of the cultural mores surrounding sexual practices in the Northwest Territories.

32. Lay plans now for facilities which can serve as primary treatment facilities and hospices for AIDS patients. Existing programs such as homecare should be expanded.

RECOMMENDATIONS FOR REGIONAL HEALTH BOARDS

This section contains recommendations for regional health care staff who are charged with the responsibility of AIDS programming.

1. Plan for at least one person year for a position responsible for the co-ordination of AIDS-related activity in the region. Develop a well-articulated job description with activity directed at community change.

2. Locate an appropriate and dedicated budget to fund AIDS programming.

3. Provide co-ordination to local and regional groups who wish to initiate AIDS programming. Assist with locating suitable resources or developing affordable alternatives with specific local context.

4. Lobby the headquarters of the Department of Health to provide program guidelines, assistance and training for AIDS work.

APPENDICES

APPENDIX A

SUMMARY COMPARISON OF PROJECT GOALS TO ACTIVITIES COMPLETED

The following is a summary of the objectives listed for the AIDS Project in funding proposals, along with the quantifiers which the evaluation committee accepted for their measurement, and a description of how the objective was met.

Unfortunately, the AIDS Project files do not contain the same level of information detail nor the same type of records from year to year, thus there is no complete accurate documentation of all the activities which were undertaken by AIDS staff to achieve their objectives. The examples given below were recorded mainly for the 1988/1989 year.

Quantifier	How Met
Information Collection	
Gather and collate up-to-date information about AIDS (1988/89, 1989/90)	
- one staff person to attend at least 2 meetings per year of a nationally or internationally based AIDS organization	- two staff members attended three conferences during 1988/1989
- make at least 1 contact per month with a nationally or internationally based AIDS organization or the Medical Directorate	- frequent contact with Medical Directorate
- be placed on mailing lists of all major community based and nationally based AIDS organizations	- AIDS Project was on mailing lists of community based AIDS organizations in Canada and American native AIDS organizations

- keep a current newspaper clipping file of articles relating to new AIDS information, from publications of national distribution and professional development publications	- clipping file was kept
- establish and maintain sources of information relating to HIV/AIDS for the use of GNWT and other professionals	- information files were kept by research officer - videos and written materials were collected by Otto Schaefer Library for loan to health care professionals and other caregivers - videos from elsewhere were regularly screened and purchased for the library

Assess the prevalence of injection drug use in the NWT in consultation with the Medical Directorate, Social Services and law enforcement officers and design and implement an appropriate HIV intervention strategy. (1990/91)

	- collection of information completed. Intervention strategy not planned or implemented.

Product Development and Distribution

Produce and distribute English and Native language HIV/AIDS educational materials (print, audio, visual.) (1987/1988)

Make up-to-date information about AIDS easily accessible to, and language appropriate for, NWT residents. (1988/89,1989/90)

Produce and distribute AIDS educational materials (print, audio and audiovisual) which are translated into native languages and in English. These are designed to be culturally relevant to NWT residents. (1988/89,1989/90)

- develop and distribute materials in English and native languages	- development and distribution of: - purple and white pamphlets - green pamphlets "what everyone should know about AIDS" - posters "STOPPING AIDS IS UP TO YOU" and "STOPPING AIDS IS UP TO US" - posters for World AIDS day with HOTLINE number - newspaper ads in 9 NWT papers - "UPDATE" published quarterly for health care professionals for about two years - contributed to the development of AIDS unit of school health curriculum
- materials are to be updated and revised annually	- original poster was updated - green pamphlets replaced purple pamphlets - "UPDATE" discontinued; AIDS information now included in broader based "HEALTHBEAT" - radio ads for western Arctic are currently being updated
- native language materials will be reviewed by native language experts to assure correct translation	- translations were back translated, but sometimes by the same people who had done original translations

- a strategy to manage distribution and pricing of information materials will be developed	- for non-NWT produced materials:
	  - samples only are provided user pays for quantity
	- for NWT produced materials:
	  - quantities free until supply runs out, then user pays

- information materials will be reviewed by expert resource persons to ensure accuracy of factual details and appropriateness of message	- materials were reviewed by Medical Directorate and Advisory Committee - materials were not consistently reviewed by marketing experts

- newspaper ads will be run in all major NWT publications	- ads were run in 9 NWT papers, still appear in some inflight magazines
- radio ads will be prepared for airing	- radio ads were aired in eastern Arctic; ads for western Arctic now being prepared
- radio dramas will be developed by native theatre groups in the eastern and western Arctic and aired	- a radio drama was developed and aired in the western Arctic for Dene listeners - none were developed for Inuit listeners in the eastern Arctic
- a specifically designed pamphlet will be distributed to every household in the NWT by mail	- door-to-door campaign was launched in every community
- a specific marketing strategy will be developed to heighten the impact of AIDS public information dissemination	- no overall strategy was employed - newspaper and TV ads were discontinued to reduce costs and exposure
- target group audiences will rate materials as being interesting, helpful, appropriate to their lifestyle and cultural values	- most materials are unknown to most research respondents - newspapers ads, posters, and green pamphlets receive mostly favourable ratings - videos from outside NWT given poor ratings for language and lifestyle
- NWT public will rate AIDS/HIV information as being easy to obtain and easy to understand	- purple pamphlets given consistently poor ratings for reading level - green pamphlets given good ratings for graphics, mixed ratings for boldness, mixed ratings for language - posters given good ratings for message, are everywhere - pamphlets and videos given ratings for distribution policy

- materials for specific occasions (e.g. World AIDS Day) will be ready for distribution at least 2 weeks prior to event	- poor ratings; many respondents unaware of materials, or received months after event - some respondents complained about Inuktitut language advertising HOTLINE when HOTLINE service was in English only
- materials for general distribution will be distributed to a selected mailing list in accordance with a policy for distribution	- first poster given by hand to workshop participants, second poster mailed to agencies, pamphlets mailed to agencies and regional health boards who controlled local distribution
- a periodical newsletter will be distributed to members of the Legislative Assembly	- was done for the first two years

Develop an HIV prevention video in conjunction with local cultural theatre groups for use in community education. (1990/91)

	- not yet done

Revise the current television public service announcements. (1990/91)

- psa's will be revised annually	- in progress

Counselling

Provide information, counselling and referral services to persons affected by HIV/AIDS. (1987/1988)

Provide information, counselling and referral services to persons with AIDS, HIV-positive persons, their families, friends, lovers and the worried well during office hours. (1988/89, 1989/90).

- a 24-hr. 800 line will respond to calls	- line was answered in person during office hours, recorded message after hours

- all calls received will be answered in person by a qualified HIV/AIDS counsellor	- normally was answered by qualified counsellor or nurse
- a qualified HIV/AIDS counsellor will provide informal counselling as required	- service was usually available, rarely used
- statistics re age and sex of client, type of information requested and nature of referrals will be maintained on a monthly basis to guide future AIDS programming	- statistics were kept, with differing levels and types of detailed information recorded at different times
- assistance in the form of educational materials, training, and consultation will be provided on an "as needed basis" to Regional Health Centres and other community groups wishing to provide counselling and information services	- service available but not frequently if ever used
- concrete assistance will be provided within 2 weeks of a request for assistance	- service available but rarely used

Training

Provide training for a variety of groups, including health, social service and educational professionals and managers. (1987/1988)

Provide training for a variety of groups - volunteers, Health, Social Services and Education professionals, managers, "first response" personnel and others. (1988/89,1989/90)

- workshops will be delivered in each region per year	- workshops delivered in almost every community in 1987, in 2 regions in 1988, in 2 regions in 1989 and 3 in 1990
- participants will rate training as being helpful, directly related to their job requirements, and convenient re time and location	- records available for 1989/90 ratings are very good
- statistics re number of participants, job titles and locations of trainees will be maintained	- statistics were kept

Develop and provide an education program for GNWT personnel about the AIDS policy and the prevention of HIV. (1990/91)

	- input and responsibility given to Department of Personnel, their policy not yet released

Develop an HIV in the workplace education program for both public and private sectors. (1990/91)

	- done

Conduct 7 regional workshops to train the "educators" (e.g. nurses, teachers, CHR's) about the prevention of HIV infections and community attitudes. (1990/91)

- 7 workshops to be delivered in 1990/91	- two community workshops included units specifically for health care workers and other "educators"
- participants will rate workshops as being helpful, directly related to their job requirements, and convenient re time and location	- ratings good

Conduct a demonstration project using a teleconference to update health professional staff about HIV infections and policies and procedures related to this disease. (1990/91)

- not yet done

Explore the feasibility of expanding current education services to correctional centres in the NWT. (1990/91)

- initiated but no interest from Corrections staff, so no follow-up

Community Development

Promote community responsibility toward HIV prevention and management by provision of local and regional workshops. (1987/1988)

Support unique community HIV/AIDS education projects. (1987/1988)

Establish as a priority the training of native people, who can provide information and counselling informally in the communities, and in a native language. (1988/89,1989/90)

Promote community involvement and ownership of AIDS prevention and management by provision of information on-site (in local or regional workshops). The use of interactive techniques will help people to "get involved", and skills training will help NWT people to cope. (1988/89,1989/90)

- deliver workshops as requested in each region	- workshops have been delivered in each region with main focus on information in general to meet needs of specific individuals who showed up; focus was rarely if ever "community development" per se
	- not all requests have been met, especially in 1990/1991 year; some respondents complained of unanswered requests and promised visits which did not happen

- participants will rate workshops as being helpful, resulting in new community goals, relevant to community leadership and activity patterns, and relevant to community lifestyle and values	- available ratings do not mention these opinions

Promote and support unique community projects regarding AIDS prevention and education. (1988/89,1989/90)

- assistance will be provided on an "as needed basis" in the form of educational materials, training, and consultation	- one respondent complained of a refusal to support a local initiative - few other local initiatives have requested assistance

Policy and Procedures Development

Consult on public, private and government HIV/AIDS policies. (1987/1988)

Promote and support the development of appropriate public and governmental policies on AIDS, and provide co-ordination, assistance and expertise to expedite policy development and appropriate follow-through. (1988/89,1989/90)

- meet at least once with GNWT Department of Personnel officials	- AIDS Project staff drafted original policy and met several times with Personnel officials
- co-ordinate the development of intended directives regarding AIDS within the GNWT	- no record exists of requests from any department for this service
- encourage and assist employers in both the public and private sectors to develop directives and policies regarding AIDS	- no record exists of requests for this service

Consult with the Long Term Care Program about its policy and procedures re: care of a patient with HIV, and education needs of Home Care Staff. (1990/91)

- meet with officials at least once in 1990/91	- consultation is ongoing - new policy is under discussion

Review with Corrections Service their current policy and guidelines about AIDS. (1990/91)

- meet with officials at least once in 1990/91	- consultation is ongoing

APPENDIX B

DESCRIPTION OF THE STUDY

Resource Persons Interviewed

The research team travelled to two communities in each region, in each case the regional centre and one smaller community. The smaller communities were chosen on the basis of convenience of travel schedules. The following were visited:

Inuvik
Fort MacPherson
Cambridge Bay
Spence Bay
Rankin Inlet
Baker Lake
Yellowknife
Iqaluit
Pangnirtung
Fort Simpson
Fort Smith
Hay River
Rae-Edzo

In each community, the principal caregivers were interviewed. These normally included nurses, CHR's, public health nurses, adult educators, social workers, drug and alcohol counsellors, and clergy. Wherever possible, members of the regional health board and doctors were interviewed. In addition, business people, community leaders, and common citizens were also interviewed. We spoke to a few children, teens and young adults. A total of 60 interview forms were collected from community caregivers, with several of these representing groups of people (for example, a staff of several nurses and CHR responding as one).

The following table describes community respondents:

Sex: Females: 43 Males: 17

Length of Residency:	**In Community**	**In NWT**
Under 1 year	6	4
1-5 years	19	10
6-10 years	8	10
over 10 years	27	36

Language fluency: English only: 35 Read/speak native language: 25

Job Titles:

Nurse	14	Teacher	2	Doctor	3	Adult Ed	8
CHR	6	Business Person	1	Clergy	8	Counsellor	8
Friendship Centre	4	Other	6				

Nineteen former AIDS Program Staff members, senior Department of Health personnel and other representatives of the Department of Health and the Department of Education were interviewed.

Selection of respondents

Our informants were primarily people who had lived in their communities or in the Northwest Territories for more than five years, a great number for more than ten years. Medical staff were the most likely to have been in their communities for shorter periods of time. Two years was about the average tenure for nurses. Many of our informants were Dene or Inuit who were lifetime residents of their communities.

Our data was reviewed by a few special resource people, each with more than 30 years in the Northwest Territories, for their comments and suggestions.

All of the community interviewing was conducted in person by the research team. No outside interviewers were used.

Most of the AIDS Project staff were interviewed in person. Those who are now living outside of the Northwest Territories were interviewed by telephone.

Documents Reviewed

The research team reviewed available files kept on the AIDS Project which related directly to education activities. These included, for example, records of numbers and types of calls to the HOTLINE, participant reports from training seminars, and job descriptions of program staff. We did not review any confidential files, such as employee performance reports, client records, or in house memos.

Instrument Development

Two separate interview questionnaires were developed. The first questionnaire was for AIDS Project staff, representatives of the Department of Health, and people who had contributed in some way to the AIDS Project. The second questionnaire was for community caregivers and leaders.

The process of developing the questionnaires began with an examination of the goals and objectives which could be identified for various stages of the project. These were stated in the funding proposal for each year of the program's activity.

Next, in the absence of previously developed measurable performance standards for the goals and objectives, the research team referred to files kept on the activities of the project and conducted preliminary interviews of staff members. Using those records as guides, they speculated as to what type of standards might have been assumed as the project was executed.

These suggested quantifiers were then reviewed by the evaluation advisory committee for their match with what actually took place and the way records were kept. Staff were asked to consider whether or not the suggested quantifiers represented fair answers to the question: "Is this what we thought should be our goal? Is this how we decided we would know when we had finished this objective to our own satisfaction?"

After careful consideration, the group developed a set of standards which could be used to assess the activities of the AIDS education project.

These assumed standards were used as guides to developing questionnaire items. For each item, the research team anticipated the likely range of responses and created a coded response form which assigned a numerical value to each of the anticipated responses for later computer analysis. Each item also included an open-ended component to allow the interviewers to record the anecdotal comments of the informants.

Validity and Reliability Issues

No formal statistical measure of reliability was calculated. Interviewers compared their results frequently and found a high degree of consistency to the information they were collecting. A few items were modified slightly as interviewing continued, and more anecdotal comments were collected than had originally been anticipated. A collection of anecdotal comments, arranged by category, was prepared. Although these comments must remain confidential, the consistency of respondents' comments was obvious.

The validity of the questionnaire items in assessing the assumed performance standards can be assumed from the careful attention which staff paid to review of the project objectives, development of the quantifiers and approval of the questionnaires.

Type of Information Summaries and Data Analyses Performed

Data collected was subjected to computer summary according to a number of indicators which were cross-referenced. For example, all questions were indexed by community, by sex of respondent, by length of the respondent's residency in the community and by length of NWT residency.

In addition, several questions were cross-referenced to determine possible connections or patterns in responses.

In general, there was strong consistency in the responses to questions on all topics. There were no significant differences by region, by sex or by occupation. Only length of residency produced some differences, but those mostly had to do with whether or not the respondent had been around long enough to recall the AIDS public education campaign. There were no significant differences on questions relating to descriptions of community sexual attitudes and behaviours based on length of residency.

Two assumptions can be made about why the information collected was consistent:

1. The researchers sought to interview respondents who had lived in their communities long enough to have a clear picture of its sexual attitudes and behaviours. Consistency of their opinions indicates that their comments reflect widely held opinions and that the informants were fair representatives of their communities.

2. The consistency across regions, occupations, sex and age groups indicates that the opinions expressed likely paint a true picture of the lifestyles of the people of the Northwest Territories, even though it is likely an image of narrow focus.

APPENDIX C

COPIES OF QUESTIONNAIRES

QUESTIONNAIRE FOR EDUCATORS, CAREGIVERS AND OTHER COMMUNITY PROFESSIONALS

Date of Interview: Location of Interview:

Residency in community:

Residency in NWT:

A. Program Structure

1. In general, what are your job responsibilities?

2. To what position do you report?

3. What can you tell me about how AIDS education delivery is organized in your community?

    (3a) Which agencies are primarily involved in AIDS education and prevention?

    (3b) Are there any overlaps or confusions about who should do what? If yes, do they interfere with your ability to perform your AIDS education related job duties?

    (3c) What is the relationship between your job and the Department of Health AIDS education program?

    (3d) In what ways has the Department of Health AIDS Program been of help to you?

    (3e) In what ways could the Department of Health AIDS Program change to help you more?

    (3f) How would you rate the organization of AIDS education services in your community as it is now?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

B. Program Future

4. What should be the future of AIDS education in your community?

   (4a) What should the goals be for the next few years?

   (4b) What should the administrative structure look like?

   (4c) What initiatives should come from GNWT Department of Health Headquarters in Yellowknife?

   (4d) What initiatives should come from communities or regions?

   (4e) Are you aware of any information that needs to be gathered for further study?

   (4f) What are the goals of your agency for the next five years regarding AIDS education and prevention?

   (4g) What type of assistance will you require from GNWT Department of Health in order to achieve your goals?

C. AIDS Education Materials

5. What can you tell me about the effectiveness of the AIDS educational materials produced by the Department of Health in Yellowknife?

   (5a) Which materials have been made available to you?

   (Identify from 2 envelopes provided for examination: envelope 1 contains NWT-produced materials, envelope 2 contains materials from elsewhere)

   (5b) How do you go about obtaining educational materials when you need them?

   (5c) Do you usually receive what you want?

   (5d) Do you usually receive materials when you need them?

(5e) How would you rate the ease and speed of obtaining what you want?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

(5f) Which of the educational materials do you think have been most useful, helpful or successful in reaching their objectives?

(5g) On what evidence do you base your opinion?

(5h) What features do they have in common?

(5i) Which of the educational materials do you think have been least useful, helpful or successful in reaching their objectives?

(5j) On what evidence do you base your opinion?

(5k) What features do they have in common?

(5l) How would you rate the appropriateness of the language and the message to the lifestyle and values of your community?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

(5m) How would you rate the accuracy of the translation of the written materials?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

(5n) How would you rate the accuracy of the translation of the verbal materials?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

(5o) How would you rate the overall effectiveness of the educational materials?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

(5p) Where are there posters and pamphlets now in your community?

(5q) How would you rate their condition?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

D. Training Programs

6. What can you tell me about the training provided by the AIDS Program staff in Yellowknife?

(6a) Have you attended a training seminar offered by the Yellowknife AIDS Program staff?

(6b) Did it cover the topics you needed in order to be effective?

(6c) Do you think the methods used by the instructor helped you learn what you needed?

(6d) Was the instructor knowledgeable?

(6e) Were the materials helpful?

(6f) Was the timing and location convenient for you?

(6g) Have you received any follow-up training?

(6h) If you were to have updating, follow-up or advanced training, what topics would you want to have covered?

(6i) What recommendations do you have to improve training?

(6j) How would you rate the overall effectiveness of the AIDS training?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

E. Community Initiatives

7. What can you tell me about the development of any local AIDS initiatives?

(7a) Are you aware of any AIDS initiatives that have been tried in your community?

(7b) What was its (their) purpose?

(7c) How did the initiative(s) originate?

(7d) How was its (their) purpose, form and approach determined?

(7e) What factors contributed most to the success of the initiative(s)?

(7f) What type of assistance did the Yellowknife-based AIDS Program provide to the initiative(s)?

(7g) How would you rate the overall effectiveness of the initiative(s)?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

(7h) What has been the impact of the initiative on the community?

(7i) What recommendations would you give someone who wanted to try something similar in the future?

(7j) Can you describe the informal power and leadership structure in your community?

(7k) Who are the ideal people to be delivering AIDS education and prevention counselling?

(7l) What type of support do you think would be needed from the Yellowknife AIDS Program to help those natural leaders develop as AIDS resources?

(7m) What would you say is the most important need the community has now, with regards to AIDS?

F. Counselling Services

8. What can you tell me about the AIDS education and prevention counselling delivered by your agency?

(8a) What type of services do you provide?

(8b) How many requests for information or counselling about AIDS have come through your facility during the past four years?

(8c) How many people have you referred to other services available in the community during the past four years?

(8d) Where would you be most likely to send someone who had further questions or concerns about AIDS?

(8e) What gaps are there in your community regarding AIDS services?

(8f) In general terms, what type of sexual activities and attitudes are prevalent in your community?

(8g) What changes in sexual behaviour and attitudes among the members of your community have you been aware of over the past four years?

(8h) How has the number of condoms distributed by your agency changed over the past four years?

(8i) How has the number of teenage pregnancies changed over the past four years?

(8j) How has the number of STD's changed over the past four years?

(8k) What do you think would be the likely result if it were to become known that AIDS was present in your community?

G. Personal and Professional Development

9. What do you think are the key issues in professional and personal development for staff working in AIDS programs?

(9a) What structures are in place to keep you up-to-date regarding HIV/AIDS information?

QUESTIONNAIRE FOR AIDS EDUCATION PROGRAM AND RELATED STAFF, CURRENT AND FORMER

Date of Interview:

Location of Interview:

Job Title:

Residency in community:

Residency in NWT:

A. Program Structure:

1. In general, what are your job responsibilities?

2. To what position do you report?

Item 3 is specifically for those not directly involved with the current AIDS education program:

3. How does or did your job fit in with the structure and responsibilities of the AIDS education program?

   (3a) Are there any overlapping or unclear duties or reporting relationships?

   (3b) If yes, have they interfered with your ability to perform your job responsibilities?

Item 4 is for those who are formal members of the AIDS Program:

4. How well does the structure work now?

   (4a) Are there any overlapping or unclear duties or reporting relationships?

   (4b) If yes, have they interfered with your ability to perform your job responsibilities?

   (4c) If the structure doesn't work, how should it be changed?

(4d) How would you rate the administrative structure as it is now?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

B. History and Evolution of Program

5. What can you tell me about how the GNWT AIDS education programs have evolved?

   (5a) How long have you been involved with the NWT AIDS Program?

   (5b) During what time period has your involvement been?

   (5c) What percentage of your time has been spent on the NWT AIDS Program?

   (5d) How have program objectives changed during the time of your involvement?

   (5e) Why have they changed?

   (5f) How have the currently-used protocols developed?

   (5g) Why have currently-used protocols developed as they have?

   (5h) Who have been the prime influencers in the development and evolution of the programs?

6. What should be the future direction of the AIDS education programs?

   (6a) What should the goals be for the next few years?

   (6b) What should the administrative structure look like?

   (6c) What initiatives should come from GNWT Headquarters in Yellowknife?

(6d) What initiatives should come from communities or regions?

C. Program Effectiveness

7. What do you think are the most critical aspects of the AIDS education programs?

    (7a) What are the objectives of the AIDS education programs?

    (7b) What do you think contributes most to the successes of the programs?

    (7c) What are the weakest features of the programs?

    (7d) How could they be improved?

    (7e) What information needs to be collected for study?

8. How would you rate the overall effectiveness of the NWT AIDS education programs?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

D. Personal and Professional Development

9. What do you think are the key issues in professional and personal development for staff working in AIDS programs?

    (9a) What structures are in place to keep you up-to-date regarding HIV/AIDS information?

    (9b) Are you satisfied with the initiatives taken by the GNWT to ensure that you are kept up-to-date?

    (9c) If changes are required, what should they be?

E. Specific Questions for Those Involved with Development and Distribution of Educational Materials

10. What can you tell me about how the AIDS educational materials were developed?

    (10a) How were the objectives and content decided on?

    (10b) What steps were taken to ensure that the facts were correct?

    (10c) What steps were taken to ensure that the materials were language-appropriate and relevant to the lifestyle and values of the intended target audiences?

    (10d) What steps were taken to ensure that translations were accurate?

    (10e) How was it decided who should be the target audiences for educational materials?

11. What can you tell me about the effectiveness of the educational materials?

    (11a) Which of the educational materials do you think have been most useful, helpful or successful in reaching their objectives?

    (11b) On what evidence do you base your opinion?

    (11c) What features do they have in common?

    (11d) Which of the educational materials do you think have been least useful, helpful or successful in reaching their objectives?

    (11e) On what evidence do you base your opinion?

    (11f) What features do they have in common?

    (11g) How would you rate the overall effectiveness of the educational materials?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

12. What can you tell me about how educational materials are kept current?

    (12a) Who is responsible for ensuring that educational materials are kept up-to-date?

    (12b) How often are materials reviewed for their factual currency?

    (12c) Are you satisfied with the initiatives to keep materials up-to-date?

    (12d) If changes are required, what should they be?

13. What can you tell me about how educational materials are distributed?

    (13a) What is the strategy for distribution of materials?

    (13b) How was the strategy developed?

    (13c) What changes should be made for the future?

    (13d) How would you rate the overall effectiveness of the strategies that you are aware of for distribution of materials?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

14. What can you tell me about the marketing strategy that was developed for the AIDS educational program?

    (14a) What were the objectives of the marketing cycle?

    (14b) How was the marketing strategy developed?

    (14c) Which items were exposed when, and to which audiences?

    (14d) What were the factors which contributed most to the results of the marketing strategies with which you are familiar?

    (14e) What changes should be made for the future?

(14f) How would you rate the overall effectiveness of the marketing strategy?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

F. Specific Questions for those Involved with the Development and Delivery of AIDS Counselling Programs.

15. What can you tell me about how the counselling programs were developed?

    (15a) What counselling programs have been developed?

    (15b) How were the objectives of the counselling services determined?

    (15c) How were the form and structure of services decided on?

    (15d) How was it decided who should be the target audiences for counselling services?

    (15e) What steps were taken to ensure that counselling services would be relevant to the needs, lifestyles and values of the target populations they would serve?

16. What can you tell me about the effectiveness of the AIDS Hotline?

    (16a) What assessment has been done?

    (16b) What factors have contributed most to the successes of the Hotline?

    (16c) What are the weakest features of the Hotline?

    (16d) If changes are required, what should they be?

(16e) How would you rate the overall effectiveness of the Hotline?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

17. What can you tell me about the effectiveness of other counselling services?

(17a) What services other than the Hotline are you familiar with?

(17b) Which of the counselling programs do you think have been most useful, helpful or successful in reaching their objectives?

(17c) On what evidence do you base your opinion?

(17d) What features do they have in common?

(17e) Which of the counselling programs do you think have been least useful, helpful or successful in reaching their objectives?

(17f) On what evidence do you base your opinion?

(17g) What features do they have in common?

(17h) How would you rate the overall effectiveness of counselling initiatives, other than the Hotline?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

(17i) If changes are required, what should they be?

G. Specific Questions for Those Involved with Training Programs

18. What can you tell me about the development of training curricula?

    (18a) How have you been involved with the development of training curricula?

    (18b) How were the objectives for the various training curricula determined?

    (18c) How were teaching methodology and skills assessment methodology determined?

    (18d) How were student learning materials developed?

    (18e) What steps were taken to ensure that teaching methodologies and student learning materials were appropriate to the educational level, lifestyle and cultural values of the intended participants?

    (18f) What steps were taken to ensure that information and suggested behaviours were in accordance with current knowledge about HIV/AIDS?

19. What can you tell me about the effectiveness of the training programs?

    (19a) What evaluation or assessment has been done to determine the effectiveness of training courses?

    (19b) Which of the training courses do you think have been most useful, helpful or successful in reaching their objectives?

    (19c) On what evidence do you base your opinion?

    (19d) What features do they have in common?

    (19e) Which of the training courses do you think have been least useful, helpful or successful in reaching their objectives?

    (19f) On what evidence do you base your opinion?

    (19g) What features do they have in common?

(19h) How would you rate the overall effectiveness of the training programs?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

H. Specific Questions for those Involved with Community-based Initiatives:

20. What can you tell me about the development of community-based AIDS initiatives?

(20a) Where has the initiative for community-based projects come from?

(20b) How have their purpose, form and approach been determined?

21. What can you tell me about the effectiveness of community-based initiatives?

(21a) Which of the initiatives do you think have been most successful in reaching their objectives?

(21b) On what evidence do you base your opinion?

(21c) What features do they have in common?

(21d) Which of the initiatives do you think have been least successful in reaching their objectives?

(21e) On what evidence do you base your opinion?

(21f) What features do they have in common?

(21g) How would you rate the overall effectiveness of the community initiatives?

1	2	3	4	NA
Unacceptable	Poor	Fair	Excellent	No Opinion, or Unable to Judge

I. Specific Questions for Those Involved with Policy Development:

22. What can you tell me about the development of HIV/AIDS policies?

(22a) How were details of policies developed and negotiated?

(22b) What steps were taken to ensure affirmation or acceptance of policies?

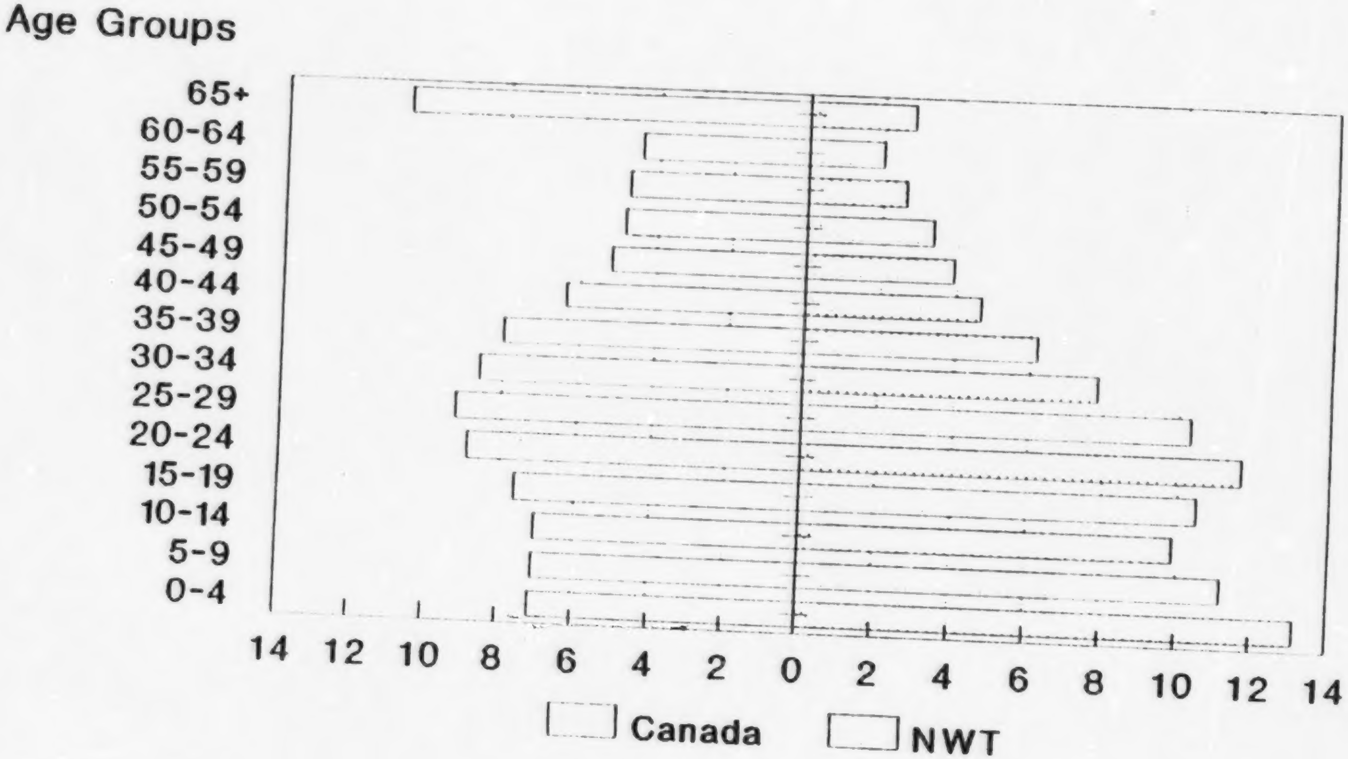
(22c) To what extent do you think your department has been successful in meeting its objective to facilitate the development of policies?

1	2	3	4	NA
Unsuccessful	Partly Successful	Mostly Successful	Extremely Successful	No Opinion, or Unable to Judge

(22d) What should be the role of GNWT in influencing the attitudes, knowledge and personal behaviour of its employees with regards to AIDS?

APPENDIX D

POPULATION BY 5 YEAR AGE GROUPS
Canada, Northwest Territories 1986
Percent of Total Population

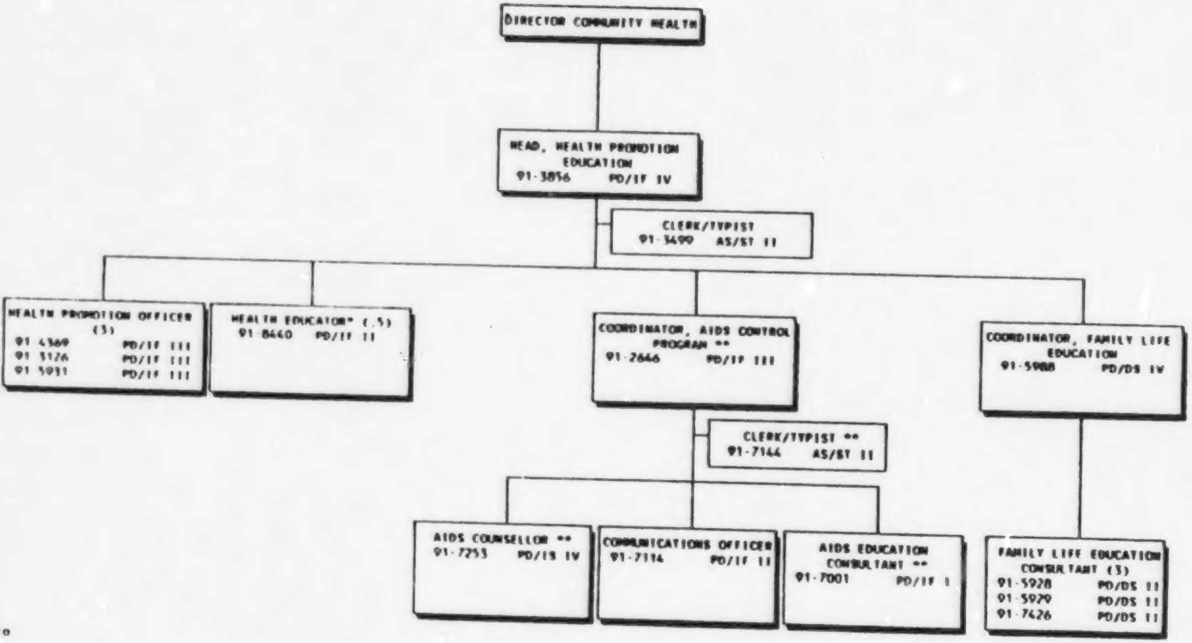


Source: GNWT Bureau of Statistics 1990

APPENDIX E

DEPARTMENT OF HEALTH
(HEADQUARTERS)

HDO 3A



* To provide Regional services to Kitikmeot, Keewatin, Mackenzie.
** Vote 4/5

September 18, 1990

APPENDIX F

AIDS ADVISORY COMMITTEE - MEMBERSHIP

The following agencies, associations, Departments and Divisions had representatives on the AIDS Advisory Committee:

NWT MEDICAL ASSOCIATION

NWT REGISTERED NURSES ASSOCIATION

DEPARTMENT OF SOCIAL SERVICES

DEPARTMENT OF EDUCATION

YELLOWKNIFE PUBLIC HEALTH UNIT

DEPARTMENT OF HEALTH STAFF:

Chief Medical Health Officer

Territorial Epidemiologist

Infectious Disease Control Nurse

Director of Nursing

Director of Community Health

Acting Head of Health Promotion

Coordinator, AIDS Project

APPENDIX G - COMMUNITY WORKSHOPS AND PRESENTATIONS

DATE	GROUP	NO.*	REGION
13-Sep-87	Keewatin Inuit Association		Keewatin
09-Oct-87	Business and Prof'l Women's Assoc.		Yellowknife
14-Oct-87	Cambridge Bay Public Meeting	20	Kitikmeot
14-Oct-87	Cambridge Bay DEW Line Workers	25	Kitikmeot
14-Oct-87	Cam. Bay Business Occupation Program	10	Kitikmeot
27-Oct-87	Hay River Public Meeting		Western Arctic
03-Nov-87	Yellowknife Public Meeting		Yellowknife
12-Nov-87	Coppermine Public Meeting		Kitkmeot
23-Nov-87	Iqaluit Public Meeting		Baffin
02-Dec-87	Inuvik Public Meeting		Inuvik
02-Feb-88	Baker Lake Public Meeting		Keewatin
25-Feb-88	Rotary Club		Yellowknife
16-Apr-88	NWT Girl Guide	30	Yellowknife
22-Apr-88	Arctic College Business Class	25	Yellowknife
10-Nov-88	Iqaluit Arctic College	20	Baffin
10-Nov-88	Iqaluit Public Meeting	27	Baffin
29-Nov-88	Arctic College Upgrading	20	Yellowknife
06-Dec-88	Arctic College Academic Studies	40	Yellowknife
09-Jan-89	Snowdrift School Senior Students	17	Western Arctic
09-Jan-89	Snowdrift Public Meeting	35	Western Arctic
10-Jan-89	Snowdrift Adult Education Class	9	Western Arctic
31-Jan-89	Arctic College Adult Education Ctr.		Western Arctic
31-Jan-89	Ft Good Hope Adult Education Class	9	Western Arctic
31-Jan-89	Ft Good Hope School	40	Western Arctic
02-Feb-89	Ft Franklin Public Meeting	25	Western Arctic
02-Feb-89	Ft Franklin School	25	Western Arctic
15-Mar-89	Rae/Edzo COP Class at School	6	Western Arctic
15-Mar-89	Rae/Edzo Adult Education Class	20	Western Arctic
20-Apr-89	YCI Young Offenders	15	Yellowknife
08-May-89	Pond Inlet Public Meeting	20	Baffin
08-May-89	Pond Inlet High School	30	Baffin
08-May-89	Pond Inlet Adult Education	14	Baffin
10-May-89	Pangnirtung High School	60	Baffin
10-May-89	Pangnirtung Public Meeting	30	Baffin
15-May-89	Iqaluit Adult Education	12	Baffin
15-May-89	Lake Harbour Public Meeting	25	Baffin
16-May-89	Lake Harbour Public School	15	Baffin
18-May-89	Iqaluit Ukkivik Residence	30	Baffin
18-May-89	Iqaluit High School	30	Baffin
18-May-89	Iqaluit Public Meeting	5	Baffin
09-Aug-89	Arviat Youth Conference	30	Keewatin
01-Oct-89	Sir John Franklin High School	60	Yellowknife
12-Oct-89	PSAC Health and Safety Workshop	20	Yellowknife
22-Oct-89	Ft Smith Conference (Uncle Gabe's)	50	Western Arctic
20-Nov-89	Ft Smith High School	42	Western Arctic

APPENDIX G - COMMUNITY WORKSHOPS AND PRESENTATIONS

DATE	GROUP	NO.*	REGION
21-Nov-89	Ft Smith High School	60	Western Arctic
21-Nov-89	Ft Smith Arctic College	3	Western Arctic
21-Nov-89	Ft Smith Elementary School	70	Western Arctic
21-Nov-89	Ft Smith Trail Cross Group Home	13	Western Arctic
22-Nov-89	Ft Smith High School	70	Western Arctic
22-Nov-89	Hay River Correctional Centre	35	Western Arctic
Jan-90	Arctic College Students		
12-Jan-90	Sir John Franklin High School	6	Yellowknife
23-Jan-90	Sir John Franklin High School	75	Yellowknife
24-Jan-90	Sir John Franklin High School	25	Yellowknife
13-Feb-90	Sir John Franklin High School	19	Yellowknife
14-Feb-90	Sir John Franklin High School	38	Yellowknife
05-Mar-90	Sir John Franklin High School	10	Yellowknife
22-Mar-90	Sissons Public School	25	Yellowknife
26-Mar-90	Inuvik Non-Health Care Prof.	10	Inuvik
27-Mar-90	Inuvik Grolier Hall Residents	28	Inuvik
01-Apr-90	High School Students		Yellowknife
09-Apr-90	Sir John Franklin High School	47	Yellowknife
09-May-90	Tree of Peace Adult Education Group	9	Yellowknife
11-Jun-90	Aklavik Grades 6, 7 and 8	15	Inuvik
11-Jun-90	Aklavik Grades 5 and 6	11	Inuvik
01-Aug-90	Coppermine Health Fair	50	Kitikmeot
02-Oct-90	PWA Visit, Northern Addictions Ctr.	12	Yellowknife
02-Oct-90	PWA Visit, High School	90	Yellowknife
02-Oct-90	PWA Visit, Yellowknife Public Mtg	50	Yellowknife
03-Oct-90	PWA Visit, High School	130	Yellowknife
04-Oct-90	PWA Visit, Junior High School	120	Yellowknife
04-Oct-90	PWA Visit, Grade 8 Students	180	Yellowknife
04-Oct-90	PWA Visit, Grade 9 Students	180	Yellowknife
16-Oct-90	Iqaluit Young Offenders	9	Baffin
16-Oct-90	Iqaluit Youth Fair'90	64	Baffin
17-Oct-90	Iqaluit Public Meeting	1	Baffin
19-Oct-90	Baffin Correctional Centre	20	Baffin
24-Oct-90	Project Change School	17	Yellowknife
07-Nov-90	Holman Island Adult Ed. Class	11	Inuvik
07-Nov-90	Holman Island Public Meeting	11	Inuvik
07-Nov-90	Holman Island Senior Class	15	Inuvik
17-Nov-90	Ft. Smith Youth Fair	23	Western Arctic
21-Nov-90	Paulatuk Students		Inuvik
21-Nov-90	Paulatuk Public Meeting	18	Inuvik
01-Dec-90	YWCA Youth of the 90's (nov-dec'90)		Yellowknife
07-Dec-90	Yellowknife High School	12	Yellowknife

NO.* = the number of participants

APPENDIX H - WORKSHOPS AND PRESENTATIONS FOR PROFESSIONALS

DATE	GROUP	NO.*	REGION
08-Sep-87	Orientation Workshop	30	Yellowknife
01-Oct-87	Teachers of the School Health Program		Yellowknife
13-Oct-87	Cambridge Bay GNWT Employees	20	Kitikmeot
13-Oct-87	Cambridge Bay GNWT Employees	35	Kitikmeot
13-Oct-87	Cambridge Bay Teachers	20	Kitikmeot
14-Oct-87	Cambridge Bay Alcohol & Drug Ctr.	10	Kitikmeot
14-Oct-87	Cambridge Bay Health Centre Staff	9	Kitikmeot
27-Oct-87	Hay River Regional Workshop	50	Western Arctic
03-Nov-87	Yellowknife Regional Workshop	60	Yellowknife
11-Nov-87	Coppermine Regional Workshop	20	Kitikmeot
22-Nov-87	Iqaluit Regional Workshop	85	Baffin
01-Dec-87	Inuvik Regional Workshop	50	Inuvik
09-Dec-87	RCMP		Yellowknife
23-Feb-88	Baker Lake Regional Workshop	20	Keewatin
07-Mar-88	Briefing of NWT Legislative Assembly		Yellowknife
10-Mar-88	Eskimo Point AIDS & Abuse Workshop		Keewatin
04-Apr-88	NECHI Training Group	20	Yellowknife
01-Sep-88	Psychiatric Team		Yellowknife
14-Oct-88	Family Counselling	3	Yellowknife
10-Nov-88	Baffin Regional Health Board	15	Baffin
09-Jan-89	Snowdrift Interagency Session	6	Western Arctic
30-Jan-89	Ft Good Hope Health Committee	5	Western Arctic
01-Feb-89	Ft Franklin Health Committee Mtg	6	Western Arctic
02-Feb-89	Ft Franklin Alcohol/Drug Counsellor	1	Western Arctic
10-Mar-89	Hospital Inservice	20	Yellowknife
18-Apr-89	Department of Education Staff		Yellowknife
09-May-89	Pangnirtung Interagency Session	9	Baffin
16-May-89	AIDS in the Workplace Video Conference	46	Yellowknife
16-May-89	Lake Harbour Interagency Meeting	7	Baffin
16-May-89	Lake Harbour Teachers	3	Baffin
07-Jun-89	Rankin Inlet Board Meeting	20	Keewatin
10-Aug-89	Arviat Nurses	5	Keewatin
10-Aug-89	Arviat AIDS Awareness Committee	8	Keewatin
03-Nov-89	NWT Council of Friendship Centres		Western Arctic
21-Nov-89	Hay River Correctional Centre	10	Western Arctic
15-Jan-90	Stanton Hospital Inservice	6	Yellowknife
23-Jan-90	Iqaluit Social Services Staff	7	Baffin
23-Jan-90	Iqaluit Correctional Centre Staff	1	Baffin
23-Jan-90	Iqaluit RCMP Officers	10	Baffin
23-Jan-90	Iqaluit Nakasuk Teachers	3	Baffin
23-Jan-90	Iqaluit Young Offenders Staff	3	Baffin
30-Jan-90	MacKenzie Region NICs		Western Arctic
13-Feb-90	Iqaluit Health Campaign Training	24	Baffin
16-Feb-90	N.W.T. Teacher's Conference	4	Yellowknife

APPENDIX H - WORKSHOPS AND PRESENTATIONS FOR PROFESSIONALS

DATE	GROUP	NO.*	REGION
20-Feb-90	Hay River Canvasser Training		Western Arctic
22-Feb-90	Inuvik Health Campaign Training	12	Inuvik
27-Feb-90	Stanton Hospital Inservice	5	Yellowknife
07-Mar-90	Health Campaign Training	22	Yellowknife
09-Mar-90	Stanton Hospital Inservice	8	Yellowknife
16-Mar-90	Stanton Hospital Inservice	11	Yellowknife
27-Mar-90	Inuvik Health Care Prof.	30	Inuvik
28-Mar-90	Inuvik Health Care Prof.	20	Inuvik
23-Apr-90	Department of Health Staff	40	Yellowknife
04-May-90	N.W.T.R.N.A. Conference	70	Yellowknife
03-Oct-90	PWA Visit, Anglican Ministerial Mtg.	12	Yellowknife
03-Oct-90	PWA Visit, Stanton Hospital Staff	27	Yellowknife
05-Oct-90	PWA Visit, PC-9 Training Ctr. Staff	17	Yellowknife
05-Oct-90	PWA Visit, Dept. of Health Staff	20	Yellowknife
05-Oct-90	PWA Visit, Public Health Staff	6	Yellowknife
16-Oct-90	Iqaluit Elementary School Teachers	20	Baffin
17-Oct-90	Iqaluit GREC Teachers	15	Baffin
18-Oct-90	Iqaluit RCMP	10	Baffin
19-Oct-90	Baffin Regional Hospital Staff	12	Baffin
19-Oct-90	Iqaluit Public Health Nurses		Baffin
22-Nov-90	Paulatuk Teachers	2	Inuvik
07-Dec-90	YWCA Staff Retreat	33	Yellowknife

NO.* = the number of participants

APPENDIX I

STANDING NEWSPAPER ADS - CHRONOLOGY OF "MESSAGES"

1987

Oct. 19 - Stopping AIDS is up to you.

Oct. 26 - Learn about AIDS. It's everyone's problem.

Nov. 02 - Learn about AIDS so it won't hit your community.

Nov. 09 - Get personal; ask about AIDS.

Nov. 16 - A "no" to casual sex is a "no" to AIDS.

Nov. 23 - Going south? Don't bring AIDS back.

Nov. 30 - What is "safer" sex? Find out.

Dec. 07 - Going south for Christmas? Don't bring AIDS back.

Dec. 14 - There is no cure. There is no vaccine. Get the facts on AIDS.

Dec. 21 - AIDS is not like other sexually transmitted diseases. AIDS kills.

1988

Jan. 04 - Are you in a "high risk" group for AIDS? Find out.

Jan. 11 - Are you a bisexual male? Practice "safer" sex. Find out the facts about AIDS.

Jan. 18 - AIDS is not a "homosexual" disease. Use latex condoms with spermicide. Practice "safer" sex.

Jan. 25 - AIDS is not a "southern" disease. Use latex condoms with spermicide. Practice "safer" sex.

Feb. 01 - Relax...AIDS isn't transmitted by kitchen utensils, bathroom facilities, hugs or sneezes.

Feb. 08 - Drunk, horny...and a perfect candidate for AIDS. **Always** use latex condoms with spermicide. Practice "safer" sex.

Feb. 15 - Make 1988 an AIDS free year. Use latex condoms. Practice "safer" sex.

Feb. 22 - AIDS doesn't discriminate. AIDS is an equal opportunity disease.

Feb. 29 - AIDS. Know enough to protect yourself.

Mar. 07 - The less you know about your sexual partners, the better your chances of getting AIDS.

Mar. 14 - Get personal, get real. Talk with your partners about AIDS. Practice safer sex.

Mar. 21 - Women...if you sleep with a man who has had sex with other men, you're at risk for AIDS. So are your partners.

Mar. 28 - Looking at a new sexual partner? Ask about previous high risk activities. Use latex condoms. Practice safer sex.

- *FULL PAGE AD* ("Hide", AIDS comes north, safer sex, bisexual males, Don't Worry)

Apr. 04 - Stay healthy. Play safe. Use latex condoms. Practice safer sex.

Apr. 11 - *1/2 PAGE AD* (High Risk Groups)

Apr. 18 - More than 50,000 Canadians may carry the AIDS virus. Protect yourself. Practice safer sex.

Apr. 25 - Saying "I was drunk" won't protect you from AIDS. Always use latex condoms. Practice safer sex.

May 02 - Relax...you don't get AIDS from dishes, toilets, hugs or sneezes.

May 09 - In 1988 it's okay to talk about AIDS with your partners. Use latex condoms. Practice safer sex.

May 16 - AIDS...talk about it. It could save your life.

May 23 - In summer the South comes North. Protect yourself. Practice safer sex.

May 30 - Drunk sex can be as deadly as drunk driving. Always use latex condoms. Practice safer sex.

June 06 - Relax...you don't get AIDS by just being near someone with AIDS.

June 13 - If you're into the party and bar scene, and having sex, use latex condoms. AIDS is real.

June 20 - Using condoms can be fun, sexy and considerate. Not using condoms can be deadly.

June 27 - AIDS is real. AIDS is sexually transmitted. AIDS kills.

July 04 - NO ADS RAN; DELAYED IN GOVERNMENT MAIL.

July 11 - Having different sexual partners? Always use latex condoms. AIDS is real.

July 18 - If you're into the party and bar scene, and having sex, use latex condoms. AIDS is real.

July 25 - Condoms are available FREE at all nursing stations. Just ask the nurse.

Aug. 01 - More than 50,000 Canadians may carry the AIDS virus. Protect yourself. Use latex condoms.

Aug. 08 - Don't laugh off AIDS. You're not immune. Use latex condoms if you're having different sexual partners.

Aug. 15 - It doesn't matter if you're rich, native, northern or southern. AIDS is sexually transmitted.

Aug. 22 - Drunk sex can be as deadly as drunk driving. Use your head. Use latex condoms.

Aug. 29 - The more sexual partners you have, the greater the risk. Use latex condoms. AIDS is real.

Sep. 05 - Toll-free AIDS Hot Line, 1-800-661-0795. (In Yellowknife, 873-7017).

Sep. 12 - If you're into the party and bar scene and having sex, use latex condoms. AIDS is real.

Sep. 19 - Talk about AIDS with your sexual partners. Use latex condoms. AIDS is real.

Sep. 26 - New! TOLL FREE AIDS INFORMATION. AIDS INFORMATION HOT-LINE Call 1-800-661-0795. (In Yellowknife, 873-7017).

Oct. 03 - Relax...AIDS is not spread by hugs, coughs or sneezes.

Oct. 10 - Having condoms with you may not save your life, using one might.

Oct. 17 - AIDS is real. AIDS is sexually transmitted. AIDS kills.

Oct. 24 - Saying "I was drunk" won't protect you from AIDS. Use latex condoms. AIDS is real.

Oct. 31 - Relax...AIDS is not spread by sharing food, cups or restaurant dishes.

Nov. 07 - If you don't practice safer sex, AIDS could be your partner...for the rest of your life.

Nov. 14 - Using condoms can be fun, sexy and considerate. Not using condoms can be deadly.

Nov. 21 - Using condoms can be fun, sexy and considerate. Not using condoms can be deadly.

Nov. 28 - Both males and females have been infected in the N.W.T. Practice safer sex. Protect yourself.

Dec. 05 - The "AIDS virus" has infected both males and females in the N.W.T. Protect yourself. Practice safer sex.

Dec. 12 - Stopping AIDS is up to us. Let's talk about it.

Dec. 19 - Have a safe and loving Christmas.

Dec. 26 - NO NEWSPAPERS PUBLISHED

1989

Jan. 02 - Information on AIDS. 1-800-661-0795. In Yellowknife 873-7017. (It's free and confidential).

Jan. 09 - NO AD RUN/CHRISTMAS HOLIDAYS DELAY.

Jan. 16 - DO something about AIDS in 1989...say "NO" to unprotected sex.

Jan. 23 - In 1986, Bob had sex without a condom. In 1989, Bob can't see, hear, or remember his name. AIDS hurts before it kills.

Jan. 30 - An infected person can look and feel healthy...but still pass on the AIDS virus. Use latex condoms. Protect yourself.

Feb. 06 - Relax...you won't get AIDS from sharing food, restaurant dishes or washrooms.

Feb. 13 - Having a supply of condoms won't save your life...using them might! Condoms won't protect you unless you use them.

Feb. 20 - AIDS is in the N.W.T. AIDS is sexually transmitted. AIDS kills.

Feb. 27 - Find out if you're at risk for AIDS. Phone 1-800-661-0795. In Yellowknife 873-7017.

Mar. 06 - NO ADS RUN

Mar. 13 - It can take more than 7 years after infection for symptoms of AIDS to develop. Practice safer sex.

Mar. 20 - Have you shared needles to shoot drugs in the last 10 years? Find out about AIDS, your risk and how to protect others.

By grade 11, close to 2/3 of N.W.T. teenagers have had sexual intercourse. Talk to your children about sexuality. Teach them about safer sex.

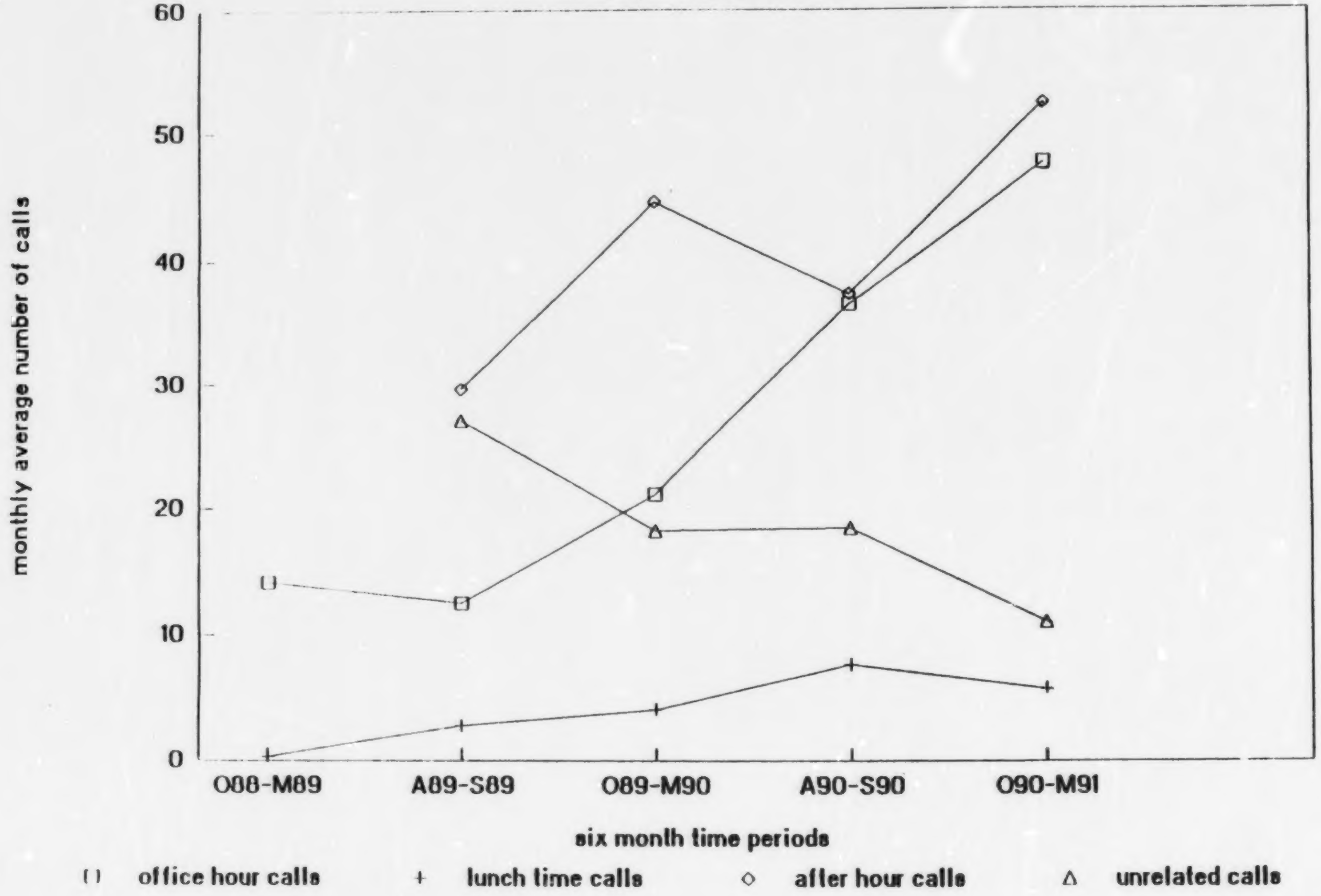
Mar. 27 - For many people, by the time it was discovered AIDS is sexually transmitted, it was too late. For you maybe it isn't...

Apr. 03 - Relax...you don't get AIDS from hugs, coughs or sneezes.

APPENDIX J

AIDS INFORMATION LINE

Summary of Calls Received



NORTHWEST TERRITORIES HEALTH CARE SYSTEM

REGIONAL HEALTH BOARDS/HOSPITALS

A	INUVIK REGIONAL HEALTH BOARD
B**	MACKENZIE REGIONAL HEALTH SERVICE
C	KITIKMEOT HEALTH BOARD
D	KEEWATIN REGIONAL HEALTH BOARD
E	BAFFIN REGIONAL HEALTH BOARD
F*	STANTON YELLOWKNIFE HOSPITAL
G	H.H. WILLIAMS MEMORIAL HOSPITAL
H	FORT SMITH HEALTH CENTRE

* Stanton Yellowknife Hospital is the Western Arctic referral centre A,B,C,F,G,H.

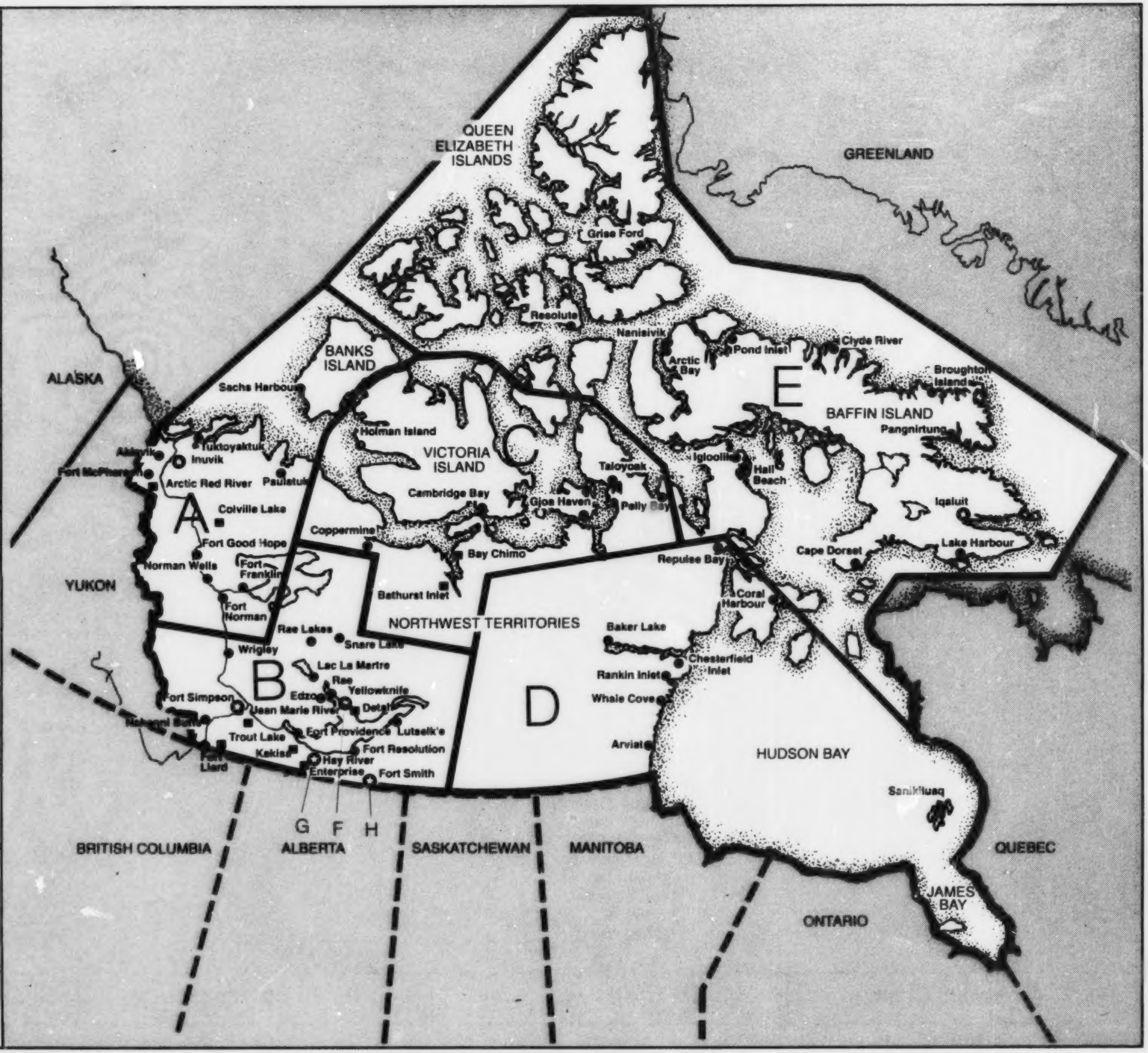
** Hay River Public Health Services are provided by Mackenzie Regional Health Services

*** Boundary lines reflect the area served by Regional Hospital/Health Boards

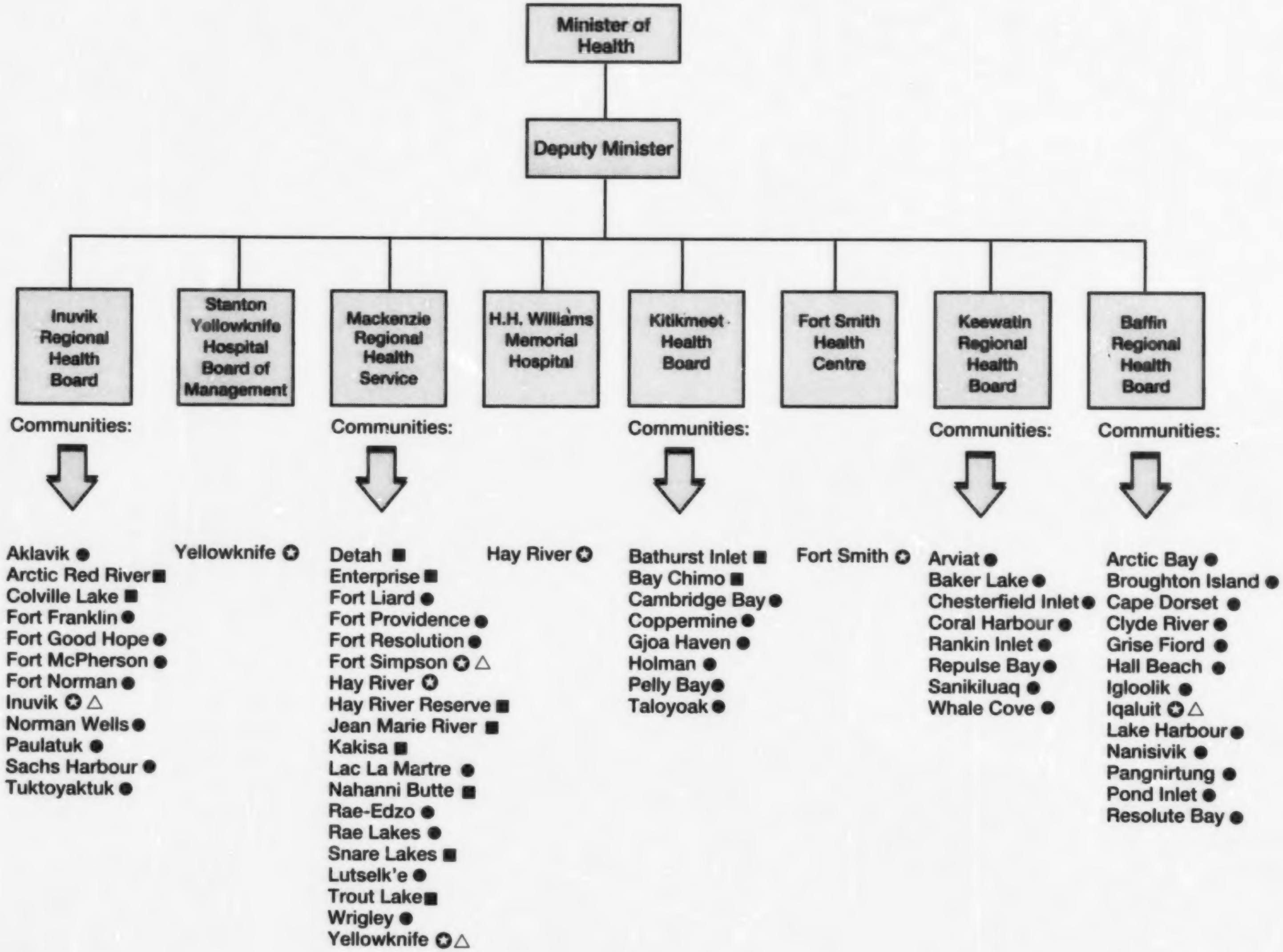
✪ HOSPITALS

● HEALTH CENTRES

■ HEALTH STATIONS



NORTHWEST TERRITORIES HEALTH BOARD ORGANIZATIONS



Minister of Health

Deputy Minister

Inuvik Regional Health Board

Communities:

- Aklavik ●
- Arctic Red River ■
- Colville Lake ■
- Fort Franklin ●
- Fort Good Hope ●
- Fort McPherson ●
- Fort Norman ●
- Inuvik ✪ △
- Norman Wells ●
- Paulatuk ●
- Sachs Harbour ●
- Tuktoyaktuk ●

Stanton Yellowknife Hospital Board of Management

- Yellowknife ✪

Mackenzie Regional Health Service

Communities:

- Detah ■
- Enterprise ■
- Fort Liard ●
- Fort Providence ●
- Fort Resolution ●
- Fort Simpson ✪ △
- Hay River ✪
- Hay River Reserve ■
- Jean Marie River ■
- Kakisa ■
- Lac La Martre ●
- Nahanni Butte ■
- Rae-Edzo ●
- Rae Lakes ●
- Snare Lakes ■
- Lutselk'e ●
- Trout Lake ■
- Wrigley ●
- Yellowknife ✪ △

H.H. Williams Memorial Hospital

- Hay River ✪

Kitikmeot Health Board

Communities:

- Bathurst Inlet ■
- Bay Chimo ■
- Cambridge Bay ●
- Coppermine ●
- Gjoa Haven ●
- Holman ●
- Pelly Bay ●
- Taloyoak ●

Fort Smith Health Centre

- Fort Smith ✪

Keewatin Regional Health Board

Communities:

- Arviat ●
- Baker Lake ●
- Chesterfield Inlet ●
- Coral Harbour ●
- Rankin Inlet ●
- Repulse Bay ●
- Sanikiluaq ●
- Whale Cove ●

Baffin Regional Health Board

Communities:

- Arctic Bay ●
- Broughton Island ●
- Cape Dorset ●
- Clyde River ●
- Grise Fiord ●
- Hall Beach ●
- Igloolik ●
- Iqaluit ✪ △
- Lake Harbour ●
- Nanisivik ●
- Pangnirtung ●
- Pond Inlet ●
- Resolute Bay ●

● Health Centres	✪ Hospitals	■ Health Stations	△ Public Health Unit

Native Languages of the NWT

Languages, like people, come in families. French, Spanish and Italian belong to one family; Czech, Polish and Ukrainian belong to another family.

In the NWT, there are three families of native languages.

Most Native Indian people in the Mackenzie Valley speak one of the Dene languages; Gwich'in, North Slavey, South Slavey, Chipewyan, and Dogrib. This language family extends into Alberta, Saskatchewan, British Columbia, Alaska and the southwestern United States.

In all, about 6,000 people use these languages. At the moment, the Dene languages are basically oral, since few people in the Territories (probably no more than 400) can read or write them well. Although some elders still use syllabics, Dene languages are now written in Roman orthography and the alphabets have been standardized.

A small number of people in the Territories speak Cree. Their language belongs to a different linguistic family, Algonquian. Cree is closely related to such languages as Ojibway, Saulteaux, and Montagnais.

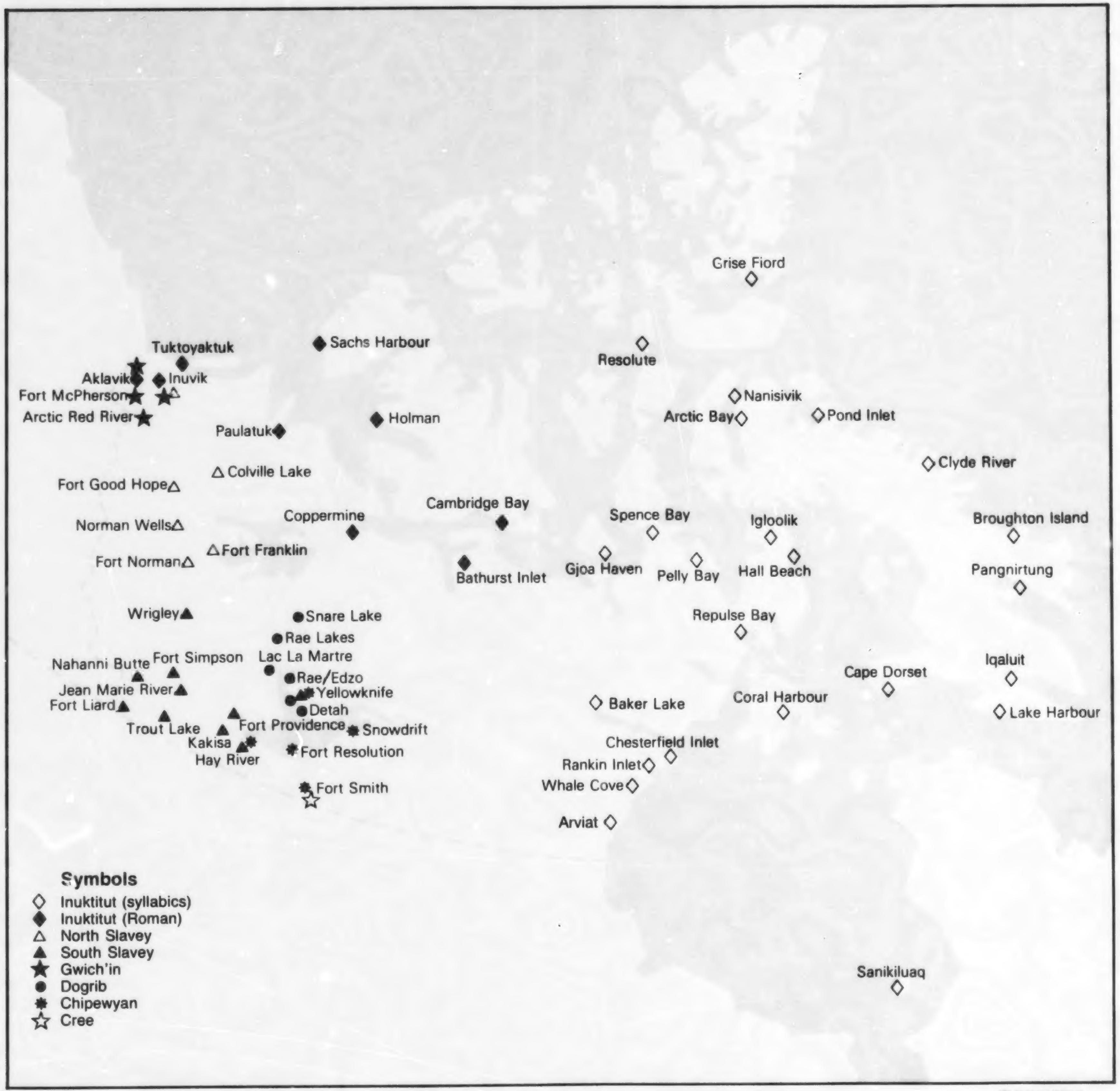
In the East and along the Arctic Coast, most people speak a version of the Inuit language. In general, this language is referred to as Inuktitut, but the people of the Delta and Western Arctic prefer to use their local names for it – Inuvialuktun and Inuinnaqtun.

There are six major dialects of Inuktitut in the NWT: Northern Quebec, Baffin, Keewatin, Arctic Coast, Western Arctic, and Delta. Some are similar to one another, with only slight variations in pronunciation and vocabulary. But others are very different, so that Inuit from different areas may have trouble understanding each other. (English-speakers from mainland Canada often run into similar problems when they visit Newfoundland, for example, or certain parts of the British Isles.)

Inuktitut is written in two different ways. "Roman orthography", the same symbols that are used for English, is used in the West, while syllabics, symbols specially devised for native languages, are used in the East.

Inuktitut is spoken by about 14,000 people in the Territories. Most Inuit read and write their language well.

Community	Native Language(s) Spoken
Aklavik	Inuvialuktun (Inuktitut) Gwich'in
Arctic Bay	Inuktitut
Arctic Red River	Gwich'in
Baker Lake	Inuktitut
Bathurst Inlet	Inuinnaqtun (Inuktitut)
Broughton Island	Inuktitut
Cambridge Bay	Inuinnaqtun (Inuktitut)
Cape Dorset	Inuktitut
Chesterfield Inlet	Inuktitut
Clyde River	Inuktitut
Colville Lake	North Slavey
Coppermine	Inuinnaqtun (Inuktitut)
Coral Harbour	Inuktitut
Detah	Dogrib
Arviat	Inuktitut
Fort Franklin	North Slavey
Fort Good Hope	North Slavey
Fort Liard	South Slavey
Fort McPherson	Gwich'in
Fort Norman	North Slavey
Fort Providence	South Slavey
Fort Resolution	Chipewyan
Fort Simpson	South Slavey
Fort Smith	Chipewyan Cree
Gjoa Haven	Inuktitut
Grise Fiord	Inuktitut
Hall Beach	Inuktitut
Hay River	South Slavey Chipewyan
Holman	Inuinnaqtun (Inuktitut)
Igloolik	Inuktitut
Inuvik	Inuvialuktun (Inuktitut) Gwich'in North Slavey
Iqaluit	Inuktitut
Jean Marie River	South Slavey
Kakisa	South Slavey
Lac La Martre	Dogrib
Lake Harbour	Inuktitut
Nahanni Butte	South Slavey
Nanisivik	Inuktitut
Norman Wells	North Slavey
Pangnirtung	Inuktitut
Paulatuk	Inuvialuktun (Inuktitut)
Pelly Bay	Inuktitut
Pond Inlet	Inuktitut
Rae-Edzo	Dogrib
Rae Lakes	Dogrib
Rankin Inlet	Inuktitut
Repulse Bay	Inuktitut
Resolute	Inuktitut
Sachs Harbour	Inuvialuktun (Inuktitut)
Sanikiluaq	Inuktitut
Snare Lake	Dogrib
Snowdrift	Chipewyan
Spence Bay	Inuktitut
Trout Lake	South Slavey
Tuktoyaktuk	Inuvialuktun (Inuktitut)
Whale Cove	Inuktitut
Wrigley	South Slavey
Yellowknife	South Slavey Chipewyan Dogrib



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Northwest Territories Culture & Communications

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